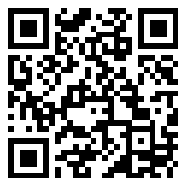

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**FAMILY PLANNING SERVICES AND POPULATION
RESEARCH AMENDMENTS OF 1973**

HEARINGS

BEFORE THE

SPECIAL SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON

LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

NINETY-THIRD CONGRESS

FIRST SESSION

ON

S. 1708

**A BILL TO AMEND TITLE X OF THE PUBLIC HEALTH SERVICE
ACT TO EXTEND APPROPRIATIONS AUTHORIZATIONS FOR
THREE FISCAL YEARS AND TO REVISE AND IMPROVE
AUTHORITIES IN SUCH TITLE FOR FAMILY PLANNING SER-
VICES PROGRAMS, PLANNING, TRAINING AND PUBLIC INFOR-
MATION ACTIVITIES, AND POPULATION RESEARCH**

S. 1632

**TO EXTEND FOR THREE YEARS THE PROGRAMS FOR COMPRE-
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COMPREHENSIVE PUBLIC HEALTH SERVICE AND HEALTH
SERVICES DEVELOPMENT, AND TO REPEAL A REQUIREMENT
THAT AT LEAST 15 PER CENTUM OF A STATE'S FORMULA
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ONLY FOR MENTAL HEALTH SERVICES**

MAY 8, 9, 10, AND 23, 1973

Printed for the use of the Committee on Labor and Public Welfare

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FAMILY PLANNING SERVICES AND POPULATION RESEARCH AMENDMENTS OF 1973

TUESDAY, MAY 8, 1973

U.S. SENATE,
SPECIAL SUBCOMMITTEE ON HUMAN RESOURCES
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:15 p.m. in room 4232, Dirksen Office Building, Senator Alan Cranston (chairman of the subcommittee) presiding.

Present: Senator Cranston.

Committee staff members present: Jonathan R. Steinberg, counsel to the subcommittee; Louise Ringwalt, research analyst; and Jay Cutler, minority counsel.

Senator CRANSTON. The hearing will please come to order.

This afternoon we begin hearings on the first extension of the Family Planning Services and Population Research Act of 1970, Public Law 91-572.

In 1970, this act was the culmination of years of effort on the part of many groups and individuals to make family planning services available to all those who wanted but could not afford them, as well as to improve our knowledge in the fields of human reproduction and population dynamics so that each individual family could determine its size by choice rather than by force of circumstances.

On May 3, I introduced S. 1708, the bill before this subcommittee today, to extend the provisions of title X of the Public Health Service Act as added by Public Law 91-572, and to improve and tighten its provisions to meet more clearly community needs and congressional intent.

S. 1708 has very broad support in the Senate and currently is cosponsored by 19 other Senators of both parties, including the chairman and ranking minority member of the full committee.

The cosponsors are: Senators Taft, Williams, Javits, Baker, Bayh, Brooke, Case, Goldwater, Hart, Hughes, Inouye, Jackson, McGee, McGovern, Metcalf, Moss, Muskie, Packwood, and Stevenson.

This bill reflects a number of concerns which have been voiced by individuals receiving services under projects authorized by title X, by the organized programs eligible for assistance under title X, and by experts in the health field who either provide these services or conduct research or training programs supported by title X.

These recommendations have been communicated to us over the last 2 years, as a result of 6 days of oversight hearings held by this subcommittee, and were based upon the experience gained since enactment of the 1970 act.

In some cases, these concerns resulted from lack of specificity in the law as to exact congressional intent. One example of this is the lack of definition of "low income" in the statute. The current law leaves that definition to the discretion of the Secretary in carrying out the statutory priority for services assigned to "low income" persons.

Last year when regulations were finally issued defining "low income," the definition was so complex, it resulted in considerable confusion among the programs, not only in interpreting exactly who met the definition, but also in determining if the regulations required a fee to be charged to an individual from non-low-income families.

S. 1708 would define "low income" as that level referred to by the Bureau of Labor Statistics as the "lower living standard budget." Currently, this figure is \$7,214 per year for a family of four. In addition, S. 1708 prohibits the charging of any fee in programs supported by title X except to the extent that payment will be made by a third party, and further prohibits questioning of any individual as to his income level.

To insure that services will be provided to those wishing them but unable to afford them, the proposed legislation requires projects or programs receiving assistance to be located in areas most accessible to low-income families.

Another concern to which S. 1708 responds is that family planning services are preventive health services and should be provided in coordination with related health services. The legislation requires that, wherever feasible, projects or programs make arrangements for a comprehensive range of child and maternal health services, including infertility services, to be offered to individuals to whom family planning services are offered under title X.

New language would be added to title X by S. 1708 to protect the interests of any individuals participating in contraceptive development research programs to require, in advance, full and informed written consent on the part of the individual after full written disclosure of risks is made. S. 1708 further limits the use of drugs to only those purposes for which FDA approval has been given, except in cases certified as medically permissible in conformance with regulations prescribed by HEW in rulemaking under the Administrative Procedure Act.

Other provisions which I believe are essential in any organized program of health services are also included; namely, the requirement that persons served by projects or programs be represented on the policymaking body of the program or project and the further requirement that the 314(a) and 314(b) comprehensive health planning agencies be given an opportunity for review and submission of nonbinding comments on applications for project support under title X. I have offered these two provisions consistently as amendments to all legislation before this committee relating to the provision of health services since I have been in the Senate.

When the original Public Law 91-572 was considered in Congress, a great many discussions were held with the administration on the organizational structure needed to implement the programs authorized by the new legislation. An agreement was reached whereby there would be a Deputy Assistant Secretary for Population Affairs with responsibility and authority for all the Department's programs in popula-

tion research and family planning. He was also to have line authority over both the research program of the Center for Population Research and the services program of the National Center for Family Planning Services.

This authority HEW proposed was to be exercised through two individuals selected by the Deputy Assistant Secretary who would serve as his special assistants and would in addition have the titles, respectively, of Assistant Director of NIH for Population Research in the case of the Center for Population Research, and Assistant Administrator of HSMHA for family planning services in the case of the National Center for Family Planning Services.

Three years later no one holds these special assistant positions. The centralized duties which were carefully laid out in the Department's proposal have been deemphasized, and the Deputy Assistant Secretary's authority has been left unclear, leaving him in the position of persuader rather than director.

S. 1708, therefore, proposes a return to an organizational structure more closely related to that originally agreed upon in 1970 and provides for a statutory base for the organizational structure. It would establish an Office of Family Planning and Population Science, to be headed by an Assistant Secretary to be appointed by the President, by and with the advice and consent of the Senate. His functions and responsibilities are clearly defined, and two national centers are established directly under his office—a National Center for Family Planning Services, and a National Center for Population Science, each with Directors appointed by the Assistant Secretary.

In addition, a National Advisory Council on Family Planning and Population Science is established which would exercise peer review authority over research programs supported in the fields of human reproduction, the provision of family planning services, and population dynamics, and review and submit comments on all policies and regulations proposed to govern family planning and research activities carried out by the Department.

These changes and others I have not detailed here, will, I believe, strengthen the ability of programs supported under the authority of title X of the Public Health Service Act to meet the national need to provide safe and effective ways for all those families wanting to plan their size to do so.

I believe the safeguards and specifics we are proposing to include in the statute will enable these programs to be implemented with the greatest respect for human rights and dignity.

I cannot accept the administration's proposal not to extend any of the authorities of title X, but instead to support family planning programs under the general authorities of the so-called partnership for health legislation; specifically, the section 314(e) health services development authority. Placing these programs under that authority would mean the specific authorization and relationship between services, training, research, and education, presently contained in title X, would be lost.

Family planning programs can only be effective if sufficient manpower is trained, if good information and educational materials are developed and made available to those wishing information, and if a strong research program is instituted in the fields of human reproduc-



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FAMILY PLANNING SERVICES AND POPULATION RESEARCH AMENDMENTS OF 1973

TUESDAY, MAY 8, 1973

U.S. SENATE,
SPECIAL SUBCOMMITTEE ON HUMAN RESOURCES
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:15 p.m. in room 4232, Dirksen Office Building, Senator Alan Cranston (chairman of the subcommittee) presiding.

Present: Senator Cranston.

Committee staff members present: Jonathan R. Steinberg, counsel to the subcommittee; Louise Ringwalt, research analyst; and Jay Cutler, minority counsel.

Senator CRANSTON. The hearing will please come to order.

This afternoon we begin hearings on the first extension of the Family Planning Services and Population Research Act of 1970, Public Law 91-572.

In 1970, this act was the culmination of years of effort on the part of many groups and individuals to make family planning services available to all those who wanted but could not afford them, as well as to improve our knowledge in the fields of human reproduction and population dynamics so that each individual family could determine its size by choice rather than by force of circumstances.

On May 3, I introduced S. 1708, the bill before this subcommittee today, to extend the provisions of title X of the Public Health Service Act as added by Public Law 91-572, and to improve and tighten its provisions to meet more clearly community needs and congressional intent.

S. 1708 has very broad support in the Senate and currently is cosponsored by 19 other Senators of both parties, including the chairman and ranking minority member of the full committee.

The cosponsors are: Senators Taft, Williams, Javits, Baker, Bayh, Brooke, Case, Goldwater, Hart, Hughes, Inouye, Jackson, McGee, McGovern, Metcalf, Moss, Muskie, Packwood, and Stevenson.

This bill reflects a number of concerns which have been voiced by individuals receiving services under projects authorized by title X, by the organized programs eligible for assistance under title X, and by experts in the health field who either provide these services or conduct research or training programs supported by title X.

These recommendations have been communicated to us over the last 2 years, as a result of 6 days of oversight hearings held by this subcommittee, and were based upon the experience gained since enactment of the 1970 act.

In some cases, these concerns resulted from lack of specificity in the law as to exact congressional intent. One example of this is the lack of definition of "low income" in the statute. The current law leaves that definition to the discretion of the Secretary in carrying out the statutory priority for services assigned to "low income" persons.

Last year when regulations were finally issued defining "low income," the definition was so complex, it resulted in considerable confusion among the programs, not only in interpreting exactly who met the definition, but also in determining if the regulations required a fee to be charged to an individual from non-low-income families.

S. 1708 would define "low income" as that level referred to by the Bureau of Labor Statistics as the "lower living standard budget." Currently, this figure is \$7,214 per year for a family of four. In addition, S. 1708 prohibits the charging of any fee in programs supported by title X except to the extent that payment will be made by a third party, and further prohibits questioning of any individual as to his income level.

To insure that services will be provided to those wishing them but unable to afford them, the proposed legislation requires projects or programs receiving assistance to be located in areas most accessible to low-income families.

Another concern to which S. 1708 responds is that family planning services are preventive health services and should be provided in coordination with related health services. The legislation requires that, wherever feasible, projects or programs make arrangements for a comprehensive range of child and maternal health services, including infertility services, to be offered to individuals to whom family planning services are offered under title X.

New language would be added to title X by S. 1708 to protect the interests of any individuals participating in contraceptive development research programs to require, in advance, full and informed written consent on the part of the individual after full written disclosure of risks is made. S. 1708 further limits the use of drugs to only those purposes for which FDA approval has been given, except in cases certified as medically permissible in conformance with regulations prescribed by HEW in rulemaking under the Administrative Procedure Act.

Other provisions which I believe are essential in any organized program of health services are also included; namely, the requirement that persons served by projects or programs be represented on the policymaking body of the program or project and the further requirement that the 314(a) and 314(b) comprehensive health planning agencies be given an opportunity for review and submission of nonbinding comments on applications for project support under title X. I have offered these two provisions consistently as amendments to all legislation before this committee relating to the provision of health services since I have been in the Senate.

When the original Public Law 91-572 was considered in Congress, a great many discussions were held with the administration on the organizational structure needed to implement the programs authorized by the new legislation. An agreement was reached whereby there would be a Deputy Assistant Secretary for Population Affairs with responsibility and authority for all the Department's programs in popula-

tion research and family planning. He was also to have line authority over both the research program of the Center for Population Research and the services program of the National Center for Family Planning Services.

This authority HEW proposed was to be exercised through two individuals selected by the Deputy Assistant Secretary who would serve as his special assistants and would in addition have the titles, respectively, of Assistant Director of NIH for Population Research in the case of the Center for Population Research, and Assistant Administrator of HSMHA for family planning services in the case of the National Center for Family Planning Services.

Three years later no one holds these special assistant positions. The centralized duties which were carefully laid out in the Department's proposal have been deemphasized, and the Deputy Assistant Secretary's authority has been left unclear, leaving him in the position of persuader rather than director.

S. 1708, therefore, proposes a return to an organizational structure more closely related to that originally agreed upon in 1970 and provides for a statutory base for the organizational structure. It would establish an Office of Family Planning and Population Science, to be headed by an Assistant Secretary to be appointed by the President, by and with the advice and consent of the Senate. His functions and responsibilities are clearly defined, and two national centers are established directly under his office—a National Center for Family Planning Services, and a National Center for Population Science, each with Directors appointed by the Assistant Secretary.

In addition, a National Advisory Council on Family Planning and Population Science is established which would exercise peer review authority over research programs supported in the fields of human reproduction, the provision of family planning services, and population dynamics, and review and submit comments on all policies and regulations proposed to govern family planning and research activities carried out by the Department.

These changes and others I have not detailed here, will, I believe, strengthen the ability of programs supported under the authority of title X of the Public Health Service Act to meet the national need to provide safe and effective ways for all those families wanting to plan their size to do so.

I believe the safeguards and specifics we are proposing to include in the statute will enable these programs to be implemented with the greatest respect for human rights and dignity.

I cannot accept the administration's proposal not to extend any of the authorities of title X, but instead to support family planning programs under the general authorities of the so-called partnership for health legislation; specifically, the section 314(e) health services development authority. Placing these programs under that authority would mean the specific authorization and relationship between services, training, research, and education, presently contained in title X, would be lost.

Family planning programs can only be effective if sufficient manpower is trained, if good information and educational materials are developed and made available to those wishing information, and if a strong research program is instituted in the fields of human reproduc-

tion and population dynamics. It is my belief that the proper coordination of these programs can best be carried out through specific authorities and with the organizational structure proposed by S. 1708.

We will be hearing today from the administration; from Planned Parenthood, the largest organization supporting family planning programs; from a major family planning program in California; from a panel of distinguished religious leaders; and from an outstanding researcher in the field of biomedical research.

I would like to say that I am very disappointed that as in prior years, we have not yet received from HEW the annual update required to be submitted on January 1 on the progress in meeting the initial 5-year plan and title X goals.

We will place in the record at this point the text of S. 1708 and my floor statement on introduction (copies of which are, by the way, available in the hearing room) and the text of S. 1632, the administration transmittal letter proposing extension of the section 314 authority through fiscal year 1976, as well as Senator Javits' remarks on introducing the administration's proposal.

[The information referred to follows:]

93d CONGRESS
1st Session

S. 1708

IN THE SENATE OF THE UNITED STATES

MAY 3, 1973

Mr. CRANSTON (for himself, Mr. BAKER, Mr. BAYH, Mr. BROOKE, Mr. CASE, Mr. GOLDWATER, Mr. HART, Mr. INOUE, Mr. JACKSON, Mr. MCGEE, Mr. McGOVERN, Mr. METCALF, Mr. MOSS, Mr. PACKWOOD, Mr. STEVENSON, Mr. TAFT, and Mr. WILLIAMS) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend title X of the Public Health Service Act to extend appropriations authorizations for three fiscal years and to revise and improve authorities in such title for family planning services programs, planning, training and public information activities, and population research.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Family Planning Serv-

4 ices and Population Research Amendments of 1973".
5 SEC. 2. Title X of the Public Health Service Act is
6 amended to read as follows:

1 "TITLE X—VOLUNTARY FAMILY PLANNING
2 AND POPULATION SCIENCE PROGRAMS

3 "DECLARATION OF PURPOSE

4 "SEC. 1000. It is the purpose of this title to provide
5 for—

6 "(1) assistance in making comprehensive volun-
7 tary family planning services readily available to all
8 persons desiring such services, particularly persons
9 from low-income families;

10 "(2) assistance in strengthening domestic research
11 in the fields of human reproduction, the provision of fam-
12 ily planning services, and population dynamics, and co-
13 ordination of such research with the present and future
14 needs of family planning programs;

15 "(3) improvement of administrative and operational
16 supervision of domestic family planning programs and
17 of domestic research programs in the fields of human
18 reproduction, the provision of family planning services,
19 and population dynamics;

20 "(4) assistance to enable public and nonprofit pri-
21 vate entities to plan and develop comprehensive pro-
22 grams of family planning services;

23 "(5) assistance to develop and make readily avail-
24 able information (including educational materials) on

1 family planning services and population dynamics to all
2 persons desiring such information;

3 “(6) evaluation and improvement of the effective-
4 ness of family planning services programs and of re-
5 search programs in the fields of human reproduction,
6 the provision of family planning services, and population
7 dynamics;

8 “(7) assistance in providing trained manpower
9 needed to effectively carry out family planning services
10 programs and research programs in the fields of hu-
11 man reproduction, the provision of family planning
12 services, and population dynamics; and

13 “(8) establishment of an Office of Family Planning
14 and Population Science in the Office of the Secretary
15 of the Department of Health, Education, and Welfare to
16 carry out or exercise concurrent responsibility for and
17 coordinate within the Federal Government all Federal
18 programs pertaining to family planning services and to
19 research in the fields of human reproduction, the pro-
20 vision of family planning services, and population
21 dynamics.

22 “PLANS AND REPORTS

23 “SEC. 1001. (a) The plan (to be carried out over a
24 five-year period for extension of family planning services to

1 all persons desiring such services, for family planning and
2 population research programs, for training of necessary
3 health manpower for programs authorized by this title and
4 other Federal laws, and for carrying out other purposes in
5 Public Law 91-572) submitted by the Secretary to the
6 Congress pursuant to section 5 (a) and (b) of Public Law
7 91-572 shall be revised and updated, and submitted, not later
8 than six months after the date of enactment of this section,
9 by the Assistant Secretary for Family Planning and Popula-
10 tion Science, after consultation with the National Family
11 Planning and Population Science Advisory Council estab-
12 lished by section 1009 (e), through the Secretary, to the
13 Congress to specify, at a minimum, on a phased basis—

14 “(1) (A) the total number of individuals (and their
15 family income levels) in the United States (i) in need
16 of family planning services, (ii) who can be served by
17 organized and comprehensive family planning services,
18 and (iii) who which can be served by family planning
19 programs under this title and other Federal laws for
20 which the Secretary has responsibility and a timetable
21 for providing services to all individuals in need of family
22 planning services;

23 “(B) the types of family planning and population
24 information and educational materials to be developed
25 under this title, Public Law 91-516 (20 U.S.C. 153

1 et seq.), and other Federal laws and the ways in which
2 such materials will be made available;

3 “(C) the research goals to be established under
4 such laws and a timetable of the progress to be made
5 toward achievement of such goals; and

6 “(D) the total manpower required to meet the
7 objectives specified pursuant to subclauses (A), (B),
8 and (C) of this subsection, with separate estimates of
9 the manpower needed to be trained under this title and
10 other laws for which the Secretary has responsibility;

11 “(2) an estimate of the total costs and personnel
12 requirements needed to meet the objectives specified
13 pursuant to clause (1) of this subsection, including an
14 estimate of such costs and requirements to be met—

15 “(A) under this title and other Federal laws
16 for which the Secretary has responsibility;

17 “(B) from nongovernmental and State and
18 local government resources; and

19 “(C) the assumptions and authorities on which
20 all such estimates are based; and

21 “(3) the steps taken to maintain and operate the
22 reporting system (to yield comprehensive data on which
23 service figures and program evaluations for the Depart-
24 ment of Health, Education, and Welfare shall be based)

1 required to be established by section 5 (b) (3) of Public
2 Law 91-572.

3 Such revised plan shall also include the specifications re-
4 quired by section 5 (c) of Public Law 91-572 with respect
5 to the objectives set forth in the plan submitted by the Sec-
6 retary pursuant to section 5 (a) and (b) of such law.

7 “(b) On or before January 1, 1975, January 1, 1976,
8 and January 1, 1977, respectively, the Assistant Secretary
9 for Family Planning and Population Science, after consulta-
10 tion with the National Family Planning and Population Sci-
11 ence Advisory Council established by section 1009 (e), shall
12 submit to the Congress, through the Secretary, a report
13 which shall, at a minimum, specify—

14 “(1) projections and a comparison of accomplish-
15 ments during the preceding fiscal year with the objec-
16 tives established for such year under the plan submitted
17 pursuant to subsection (a) of this section;

18 “(2) steps to be taken to achieve or maintain the
19 service, manpower training research, and educational
20 objectives during the remaining fiscal years of the plan
21 and any revisions in such objectives and the schedule
22 for achieving them necessary to meet or maintain these
23 objectives;

24 “(3) a full explanation of any significant dis-

1 crepancies between such objectives and actual accom-
2 plishments;

3 “(4) steps, and a timetable for their implementa-
4 tion, being taken to achieve the orderly integration of
5 comprehensive, coordinated family planning services into
6 existing comprehensive health care programs or systems
7 by June 30, 1977; and

8 “(5) any recommendations with respect to addi-
9 tional legislation or administrative action necessary or
10 desirable in carrying out such plan.

11 “(c) If the plan and subsequent reports to be submitted
12 pursuant to subsections (a) and (b) of this section are
13 submitted, prior to submission to the Congress, for review
14 by the Office of Management and Budget or any other Fed-
15 eral department or agency or official thereof (1) the plan
16 or report submitted to the Congress shall specify the changes
17 and the reasons therefor made during any such review proc-
18 ess, and (2) if any such review process delays the sub-
19 mission of such plan or report to the Congress beyond the
20 date established for such submission by this section, the
21 Assistant Secretary shall immediately on such date submit
22 to the Congress the plan or report in exactly the form it was
23 submitted to such review process,

1 "VOLUNTARY FAMILY PLANNING SERVICES, GRANTS, AND
2 CONTRACTS

3 "SEC. 1002. (a) The Secretary, with the concurrence
4 of the Assistant Secretary for Family Planning and Popu-
5 lation Science and through a National Center for Family
6 Planning Services, shall make grants to and enter into con-
7 tracts with public or nonprofit entities to assist in the estab-
8 lishment and operation of voluntary family planning pro-
9 grams and projects.

10 "(b) In making grants and contracts to provide assist-
11 ance under this section, the Secretary shall take into account
12 the number of patients to be served, the extent to which
13 family planning services are needed locally, the relative need
14 of the applicant (taking into consideration the availability
15 of third-party (including government agency) payments to
16 finance such services but only to the extent that the Secre-
17 tary determines that the applicant has been able to obtain
18 such payments on a timely and continuing basis), and its
19 capacity to make rapid and effective use of such assistance.

20 "(c) For the purposes of making grants and contracts
21 under this section to meet the services objectives specified in
22 (1) the plan and reports submitted pursuant to section 5
23 (a) and (b) of Public Law 91-572 and (2) beginning six
24 months after the date of enactment of this Act, the revised
25 plan submitted pursuant to section 1001(a) and the sub-

1 sequent reports submitted pursuant to section 1001 (b),
2 there are authorized to be appropriated \$30,000,000 for the
3 fiscal year ending June 30, 1971; \$60,000,000 for the fiscal
4 year ending June 30, 1972; \$111,500,000 for the fiscal
5 year ending June 30, 1973; \$159,500,000 for the fiscal year
6 ending June 30, 1974; \$207,500,000 for the fiscal year
7 ending June 30, 1975; and \$255,500,000 for the fiscal year
8 ending June 30, 1976.

9 “(d) For the purposes of this title, the terms ‘State’
10 and ‘United States’ include Guam, American Samoa, and
11 the Trust Territory of the Pacific Islands.

12 “TRAINING GRANTS AND CONTRACTS

13 “SEC. 1003. (a) The Secretary, with the concurrence
14 of the Assistant Secretary for Family Planning and Popula-
15 tion Science and through a National Center for Family
16 Planning Services, in consultation with the National Family
17 Planning and Population Science Advisory Council estab-
18 lished by section 1009 (c), shall make grants to public or
19 nonprofit private entities and enter into contracts with public
20 or private entities and individuals to provide the training for
21 personnel (including nurse midwives) to carry out family
22 planning services programs eligible for assistance under
23 section 1002.

24 “(b) In determining the amount of funds to be pro-

1 vided under any such grant or contract, the Secretary shall
2 insure that assistance under this title is provided only to
3 the extent that such training is not supported by a sufficient
4 amount of Federal assistance under other titles of this Act
5 or other provisions of law to meet the manpower training
6 objectives specified in (1) the plan and reports submitted
7 pursuant to section 5 (a) and (b) of Public Law 91-572
8 and (2) beginning six months after the date of enactment
9 of this Act, the revised plan submitted under section 1001
10 (a) and the subsequent reports submitted pursuant to sec-
11 tion 1001 (b). Notwithstanding any other provision of law,
12 no funds other than those appropriated under this section
13 shall be used for the training of family planning personnel
14 authorized to be supported under this section unless the
15 Assistant Secretary for Family Planning and Population
16 Science shall have concurred in the terms and conditions
17 governing the use of such funds.

18 “(c) For the purpose of making payments pursuant to
19 grants and contracts under this section to meet the training
20 objectives specified in clauses (1) and (2) of the first sen-
21 tence of subsection (b), there are authorized to be appropri-
22 ated \$2,000,000 for the fiscal year ending June 30, 1971;
23 \$3,000,000 for the fiscal year ending June 30, 1972;
24 \$4,000,000 for the fiscal year ending June 30, 1973;
25 \$5,000,000 for the fiscal year ending June 30, 1974; \$7,-

1 500,000 for the fiscal year ending June 30, 1975; and
2 \$10,000,000 for the fiscal year ending June 30, 1976.

3 "RESEARCH GRANTS AND CONTRACTS

4 "SEC. 1004. (a) In order to promote research in the
5 biomedical, contraceptive development, social science, and
6 program implementation fields related to family planning and
7 population dynamics, the Secretary, with the concurrence of
8 the Assistant Secretary for Family Planning and Population
9 Science and through a National Center for Population
10 Science, after consultation with the National Family Plan-
11 ning and Population Science Advisory Council established
12 by section 1009 (e) , shall make grants to public or nonprofit
13 entities and enter into contracts with public or private entities
14 and individuals for projects for research and research train-
15 ing (including travel subsistence expenses, and stipends) in
16 such fields, including the establishment of university-based
17 research centers.

18 "(b) Notwithstanding any other provision of law and
19 except with respect to programs and activities authorized
20 under the Foreign Assistance Act of 1961, as amended
21 (22 U.S.C. 2151-2412), (1) no funds other than those ap-
22 propriated under this section shall be used for research and
23 research training in the biomedical and contraceptive devel-
24 opment fields related to family planning, except that such
25 funds authorized to be appropriated by such other provisions

1 of law to support such development may, notwithstanding
2 any other provision of law unless enacted in express limita-
3 tion of this subsection, be expended and obligated by the
4 Assistant Secretary for Family Planning and Population
5 Science, in accordance with the provisions of this section,
6 and (2) funds provided under this section or any other pro-
7 vision of law under any contract with a profit-making entity
8 to support any contraceptive development research shall be
9 limited to not more than 50 per centum of the total cost
10 attributed to the research activity covered by such contract.

11 “(c) For the purpose of making payments pursuant
12 to grants and contracts under this section to meet the re-
13 search objectives specified in (1) the plan and reports
14 submitted pursuant to section 5 (a) and (b) of Public Law
15 91-572 and (2) beginning six months after the date of
16 enactment of this Act, the revised plan submitted pursuant
17 to section 1001 (a) and the subsequent reports submitted
18 pursuant to section 1001 (b), there are authorized to be
19 appropriated \$30,000,000 for the fiscal year ending June 30,
20 1971; \$50,000,000 for the fiscal year ending June 30, 1972;
21 \$65,000,000 for the fiscal year ending June 30, 1973;
22 \$65,000,000 for the fiscal year ending June 30, 1974;
23 \$75,000,000 for the fiscal year ending June 30, 1975; and
24 \$80,000,000 for the fiscal year ending June 30, 1976,

3 “SEC. 1005. (a) The Secretary, through the Assistant
4 Secretary for Family Planning and Population Science, in
5 consultation with the National Family Planning and Popula-
6 tion Science Advisory Council established by section 1009
7 (c), shall make grants to public or nonprofit private entities
8 and enter into contracts with public or private entities and
9 individuals for—

12 “(2) the development of educational and informa-
13 tional materials on the causes and consequences of demo-
14 graphic characteristics and trends; and

17 “(b) Notwithstanding any other provision of law, no
18 funds other than those appropriated under this section shall
19 be used for the development of educational and informational
20 materials authorized to be supported under this section unless
21 the Assistant Secretary for Family Planning and Population
22 Science shall have concurred in the terms and conditions
23 governing the use of such funds.

24 “(c) For the purpose of making payments pursuant to

1 grants and contracts under this section to meet the public
2 information and educational materials objectives specified
3 in (1) the plan and reports submitted pursuant to section
4 5 (a) and (b) of Public Law 91-572 and (2) beginning
5 six months after the date of enactment of this Act, the re-
6 vised plan submitted pursuant to section 1001 (a) and the
7 subsequent reports submitted pursuant to section 1001 (b),
8 there are authorized to be appropriated \$750,000 for the
9 fiscal year ending June 30, 1971; \$1,000,000 for the fiscal
10 year ending June 30, 1972; \$1,250,000 for the fiscal year
11 ending June 30, 1973; \$1,500,000 for the fiscal year ending
12 June 30, 1974; \$2,000,000 for the fiscal year ending
13 June 30, 1975; and \$3,000,000 for the fiscal year ending
14 June 30, 1976.

15 "REGULATIONS, PAYMENTS, AND SPECIAL CONDITIONS

16 "SEC. 1006. (a) Grants and contracts made under this
17 title shall be made in accordance with regulations which the
18 Secretary shall prescribe.

19 "(b) Grants under this title shall be payable in such
20 installments and subject to such conditions as the Secretary
21 may determine to be appropriate to assure that such grants
22 will be effectively utilized for the purposes for which made.

23 "(c) A grant may be made or contract entered into
24 under section 1002 for a voluntary family planning services
25 project or program only upon assurances satisfactory to the

1 Secretary, in accordance with regulations which he shall pre-
2 scribe, that—

3 “(1) projects or programs will be located so as to
4 serve persons from low-income families;

5 “(2) no charge will be made in such projects or
6 programs except to the extent that payment will be
7 made by a third party (including a government agency)
8 which is authorized or is under legal obligation to pay
9 such charge;

10 “(3) wherever feasible, such projects or programs
11 have made arrangements for the provision, either di-
12 rectly or through linkages with other health providers,
13 of a comprehensive range of child and maternal health
14 services, including infertility services, to those persons
15 or families to whom voluntary family planning services
16 under this title are made available;

17 “(4) substantial opportunities are provided for
18 low-income persons served by or to be served by such
19 projects or programs to participate in the decision-
20 making process of such projects or programs;

21 “(5) the State comprehensive health planning
22 agency established pursuant to section 314 (a) and the
23 areawide health planning agency (if any) established
24 pursuant to section 314 (b) have had an opportunity to
25 comment thereon, within ninety days of the submission

1 to those agencies of copies of such application, and the
2 applicant has submitted to the Secretary a reply to any
3 such comments with a view toward accommodating and
4 resolving any differences with such agency or agencies;

5 “(6) no research activity in connection with such
6 projects or programs which involves any human subjects
7 at risk will be undertaken unless such projects or pro-
8 grams have, on the basis of a peer review procedure
9 (including participation by consumers), submitted to
10 the Secretary, in accordance with regulations which
11 he shall prescribe, a certification based on such re-
12 view that, in accordance with standards prescribed in
13 such regulations, the rights and welfare of any human
14 subjects involved are adequately protected, the risks
15 to each such individual are outweighed by the potential
16 benefits to him or by the importance of the knowledge
17 to be gained, and the informed consent of such individual
18 will be obtained by appropriate methods; and

19 “(7) any drugs provided individuals shall be pre-
20 scribed only for uses indicated in the official labeling
21 approved pursuant to section 505 of the Federal Food,
22 Drug, and Cosmetic Act (21 U.S.C. 321 et seq.),
23 except when (1) in the case of the use of investigational
24 new drugs as defined in such Act, the use is in com-
25 pliance with requirements for investigational new drugs

1 and procedures for human subjects at risk in accord-
2 ance with regulations which the Secretary shall pre-
3 scribe (including full and written disclosure of the in-
4 vestigational nature of the use, and the indications and
5 contraindications associated with such use, to each
6 prospective user), or (2) use for another purpose is
7 approved by a peer review committee, in accordance
8 with regulations which the Secretary shall prescribe, or
9 (3) two physicians certify that such use is necessary in
10 a life-threatening situation.

11 For the purposes of this subsection, the term 'low-income
12 family' means a family with that income level (adjusted for
13 regional and metropolitan, urban and rural differences and
14 family size) determined annually by the Bureau of Labor
15 Statistics of the Department of Labor and referred to by
16 such Department as the 'lower living standard budget'.
17 The comments procedure established by clause (5) of this
18 subsection shall not be administered in such a way as to
19 delay the review and grant process carried out pursuant
20 to section 1002.

21 “(d) In furnishing voluntary family planning services
22 in projects or programs assisted under this title, no project
23 or program, or any person working in such project or pro-
24 gram, shall request or require any person to submit any in-

1 formation with respect to such person's or such person's
2 family's income level.

3 “(e) No grant may be made to a State health authority
4 under section 1002 unless such authority has submitted, and
5 the Secretary has approved, a statewide plan, which shall
6 be updated annually in connection with each such grant,
7 for a coordinated and comprehensive program of voluntary
8 family planning services, which shall specify, at a mini-
9 mum—

10 “(1) the number of individuals in such State (and
11 the income levels of their families) estimated to be in
12 need of and the number then receiving family planning
13 services;

14 “(2) the types of services being and, with assist-
15 ance under this section, to be provided;

16 “(3) the sources and levels of State funds to be
17 made available for such services;

18 “(4) the geographical and program priorities which
19 will govern the utilization of available Federal and
20 State financial resources for such services; and

21 “(5) assurances that the requirements of sub-
22 section (b) (6) and (7) of this section will be met.

23 Such plans shall be made available and easily accessible
24 to the Congress and the public.

1 **“VOLUNTARY PARTICIPATION**

2 **“SEC. 1007. The acceptance by any individual of family**
3 **planning services or family planning or population informa-**
4 **tion (including educational materials) provided through fi-**
5 **nancial assistance under this title (whether by grant or**
6 **contract) shall be voluntary and shall not be a prerequisite**
7 **to eligibility for or receipt of any other service or assistance**
8 **from, or to participation in, any other program of the entity**
9 **or individual that provided such services or information.**

10 **“PROHIBITION OF ABORTION**

11 **“SEC. 1008. None of the funds appropriated under this**
12 **title shall be used in programs where abortion is a method**
13 **of family planning.**

14 **“OFFICE OF FAMILY PLANNING AND POPULATION**15 **SCIENCE**

16 **“SEC. 1009. (a) There is established within the Office**
17 **of the Secretary an Office of Family Planning and Population**
18 **Science to be directed by an Assistant Secretary for Family**
19 **Planning and Population Science (hereinafter referred to as**
20 **the ‘Assistant Secretary’) who shall be appointed by the**
21 **President by and with the advice and consent of the Senate.**

22 **“(b) The Secretary shall provide such Office with such**
23 **full-time professional and clerical staff and with the services**

1 of such consultants as may be necessary to assist the Assist-
2 ant Secretary to carry out his functions under this title.

3 “(c) The Secretary shall make available to the Assistant
4 Secretary such sums as may be necessary for him to adminis-
5 ter such Office and to carry out the functions of such Office
6 under this title, including the costs of collecting the data
7 necessary for carrying out the requirements of section 1001.
8 In no event may such sums be greater than 1 per centum of
9 the total sums appropriated or made available for expenditure
10 under this title.

11 “(d) There is established within such Office a National
12 Center for Family Planning Services and a National Center
13 for Population Science, which shall, respectively, be assigned
14 and carry out the functions assigned to such Centers by this
15 title and such other duties and responsibilities as the As-
16 sistant Secretary may specify in regulations.

17 “(e) (1) The Secretary shall establish a National Fam-
18 ily Planning and Population Science Advisory Council with
19 which he and the Assistant Secretary shall consult on a
20 continuing and regular basis in administering this title. The
21 Council shall consist of the Secretary, the Assistant Secretary,
22 the Directors of the National Center for Family Planning
23 Services and the National Center for Population Science, re-
24 spectively, established by subsection (d) of this section, all of
25 whom shall serve as ex officio, nonvoting members thereof,

1 and fifteen members appointed by the Secretary. Not more
2 than ten of the appointed members of the Council shall be scientists,
3 entists, physicians, or persons representative of groups or
4 organizations specializing in family planning or research in
5 the fields of human reproduction, the provision of family
6 planning services, and population dynamics, or both, and
7 not less than five of the appointed members shall be representatives
8 from the general public who are not directly
9 related to the provision of family planning services or the
10 conduct of research in the fields of human reproduction, the
11 provision of family planning services, and population dynamics
12 (except that one such member shall be a person who
13 has been or is a recipient of services from a program or project
14 supported under this title). The Secretary shall designate
15 as Chairman of the Council one of the appointed members.

16 “(2) The functions of the Council shall be to advise,
17 consult with, and make recommendations to, the Secretary
18 (through appropriate subgroups which it shall appoint) on
19 applications received for grants and contracts in excess of
20 \$35,000 under section 1004 of this Act, and to make recommendations
21 to the Secretary with respect to the establishment
22 of policies and implementing regulations to carry out all provisions
23 of this title, including preparation and review (including any agency
24 appeal thereof) of the annual budget estimate
25 for the programs established under this title and of the plan

1 and subsequent reports required to be submitted by section
2 1001.

3 “(3) Each appointed member of the Council shall be
4 appointed for a term of four years, except that—

5 “(A) any member appointed to fill a vacancy oc-
6 ccurring prior to the expiration of the term for which
7 his or her predecessor was appointed shall be appointed
8 for the remainder of such term; and

9 “(B) of the members first appointed after the
10 effective date of this title, five shall be appointed for a
11 term of four years, five shall be appointed for a term of
12 three years, and five shall be appointed for a term of
13 one year, as designated by the Secretary at the time of
14 the appointment, except that the initial terms of mem-
15 bers appointed from the general public who are not
16 directly related to the provision of family planning serv-
17 ices or the conduct of research in the fields of human
18 reproduction, the provision of family planning services,
19 and population dynamics shall be not less than three
20 years. Appointed members may serve after the expi-
21 ration of their terms until their successors have taken
22 office.

23 “(4) A vacancy in the Council shall not affect its ac-
24 tivities, and nine voting members of the Council shall consti-

1 tute a quorum for the purpose of making recommendations
2 pursuant to paragraph (2) of this subsection.

3 “(5) Members of the Council who are not officers or
4 employees of the United States shall receive for each day
5 they are engaged in the performance of the functions of the
6 Council compensation at rates not to exceed the daily equiv-
7 alent of the annual rate in effect for grade GS-18 of the
8 General Schedule, including traveltime; and all members,
9 while so serving away from their homes or regular places of
10 business, may be allowed travel expenses, including per diem
11 in lieu of subsistence, in the same manner as such expenses
12 are authorized by section 5703, title 5, United States Code,
13 for persons in the Government service employed inter-
14 mittently.

15 “(6) The Council shall meet at the call of the Chairman,
16 but not less often than four times each year.

17 **“FUNCTIONS OF THE ASSISTANT SECRETARY FOR FAMILY**
18 **PLANNING AND POPULATION SCIENCE**

19 **“SEC. 1010. (a) The Secretary shall utilize the Assistant**
20 **Secretary to—**

21 **“(1) administer all Federal laws for which the**
22 **Secretary has administrative responsibility and which**
23 **provide for or authorize the making of grants or**
24 **contracts related to, and to exercise concurrent responsi-**

1 bility with respect to all other Federal laws providing
2 support for family planning programs and research in
3 the fields of human reproduction, the provision of fam-
4 ily planning services, and population dynamics;

5 “(2) administer and be responsible for all research
6 in the fields of human reproduction, the provision of
7 family planning services, and population dynamics car-
8 ried on directly by the Department of Health, Educa-
9 tion, and Welfare or supported by the Department
10 through grants to or contracts with entities and individ-
11 uals, and consult with the Commissioner of the Food
12 and Drug Administration in order to coordinate testing,
13 evaluation, and approval of methods of contraception
14 carried out under the provisions of the Federal Food,
15 Drug, and Cosmetic Act, as amended (21 U.S.C. 321
16 et seq.) with similar activities carried out under this
17 title;

18 “(3) act as a clearinghouse for information per-
19 taining to domestic and international family planning
20 services programs and research in the fields of human
21 reproduction, the provision of family planning services,
22 and population dynamics for use by all interested per-
23 sons and public and private entities;

24 “(4) provide a liaison with the activities carried
25 on by other agencies and instrumentalities of the Federal

1 Government relating to research in the fields of human
2 reproduction, the provision of family planning services,
3 and population dynamics;

4 “(5) administer and be responsible for the training
5 of necessary manpower for domestic family planning
6 services programs and domestic programs of research
7 in the fields of human reproduction, the provision of
8 family planning services, and population dynamics;

9 “(6) coordinate, and be responsible for, the evalu-
10 ation of the other Department of Health, Education, and
11 Welfare programs relating to family planning and to
12 research in the fields of human reproduction, the provi-
13 sion of family planning services, and population dy-
14 namics, and to make periodic recommendations to the
15 Secretary;

16 “(7) submit to him directly, with appropriate op-
17 portunity for comments by the Assistant Secretary for
18 Health and Scientific Affairs, after consultation with the
19 National Family Planning and Population Science Ad-
20 visory Council established by section 1009(e), the
21 budgets for carrying out programs of the National Cen-
22 ter for Family Planning Services and the National Cen-
23 ter for Population Science, after receiving such budget
24 proposals from the directors of such respective centers;
25 and

1 “(8) provide such staff and other support to the
2 Advisory Council established by section 1009 (e) and
3 the National Centers established by section 1009 (d)
4 as is necessary to insure the capacity of such Council
5 and such Centers, respectively, to carry out their func-
6 tions under this title effectively.

7 “(b) The Assistant Secretary shall appoint the Director
8 of the National Center for Family Planning Services and the
9 Director of the National Center for Population Science, es-
10 tablished by section 1009 (d), and such Directors shall be
11 directly responsible to him.”

12 SEC. 3. Public Law 91-572 is repealed effective upon
13 the date of enactment of this Act.

14 SEC. 4. (a) Section 3 (c) (1) of Public Law 91-516
15 (22 U.S.C. 1532 (c) (1)) is amended by adding after the
16 first sentence the following new sentence: “The Assistant
17 Secretary for Family Planning and Population Science, as
18 established by section 1009 (a) of the Public Health Serv-
19 ice Act, shall serve as an ex officio, nonvoting member of the
20 Council.”

21 (b) Section 3 (b) (3) of such Public Law (20 U.S.C.
22 1532 (b) (3)) is amended by adding at the end thereof the
23 following new sentence: “Such grants or contracts shall,
24 wherever feasible, include provision and funding for con-
25 sideration of the relation of population to the total human

1 environment, and grants or contracts including such provision
2 and any other provisions for population education shall not be
3 entered into except with the concurrence of the Assistant
4 Secretary for Family Planning and Population Science with
5 respect to such provision or provisions.”

[From the Congressional Record—Senate, May 3, 1973]

FAMILY PLANNING SERVICES AND POPULATION RESEARCH AMENDMENTS OF 1973

Mr. CRANSTON. Mr. President, I am pleased to introduce S. 1708, the proposed "Family Planning Services and Population Research Amendments of 1973," and am gratified to be joined in introducing this legislation by the Senator from Ohio (Mr. Taft), the Senator from New Jersey (Mr. Williams), the Senator from Tennessee (Mr. Baker), the Senator from Indiana (Mr. Bayh), the Senator from Massachusetts (Mr. Brooke), the Senator from New Jersey (Mr. Case), the Senator from Arizona (Mr. Goldwater), the Senator from Michigan (Mr. Hart), the Senator from Hawaii (Mr. Inouye), the Senator from Washington (Mr. Jackson), the Senator from Wyoming (Mr. McGee), the Senator from South Dakota (Mr. McGovern), the Senator from Montana (Mr. Metcalf), the Senator from Utah (Mr. Moss), the Senator from Oregon (Mr. Packwood), and the Senator from Illinois (Mr. Stevenson). The breadth of support for this measure and the title X family planning programs is illustrated by the 16 cosponsors, divided among both parties and all political philosophies.

FAMILY PLANNING SERVICES AND POPULATION RESEARCH ACT OF 1970—PUBLIC LAW 91-572

Mr. President, the original passage of the Family Planning Services and Population Research Act of 1970 (Public Law 91-572) was the culmination of years of effort on the part of many groups and individuals to make family planning services available to all those who wanted but could not afford them, as well as to improve our knowledge in the field of human reproduction and population dynamics so that each individual family could determine its size by choice rather than by force of circumstances.

Public Law 91-572 created a new title X in the Public Health Service Act, providing for grants and contracts to assist in the establishment and operation of voluntary family planning projects; to provide training for personnel to carry out such programs; to promote research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population; and to train researchers for such fields, and to assist in developing and making available family planning and population information to all those individuals desiring such information. The legislation carried clear expressions of congressional intent that—

First priority would be given in furnishing such services to persons from low-income families, and that no charge would be made to such individuals, except to the extent payment would be made by a third party;

Second, acceptance of any services or information must be voluntary and cannot be made a prerequisite to eligibility for or receipt of services; and

Third, no funds appropriated under title X are to be used in programs where abortion is a method of family planning. All of these concepts are continued in the bill I introduce today.

In addition, Public Law 91-572 provided for the establishment in the Department of Health, Education, and Welfare, of an Office of Population Affairs, directed by a Deputy Assistant Secretary for Population Affairs, whose functions were described in the law as being responsible for creating liaison and coordination among all Federal programs relating to population research and family planning, and being responsible for the administration, coordination, and evaluation of all programs in the Department of Health, Education, and Welfare related to population research and family planning.

The law further required the Secretary of Health, Education, and Welfare, to make a report to Congress setting forth a plan to be implemented over a period of 5 years to carry out the purposes set forth in the act, and to report annually to Congress on its progress in reaching the objectives outlined in the plan.

THE 5-YEAR PLAN

This plan was submitted to Congress in October of 1971 and outlined the goals as follows:

In research, the plan described three areas requiring attention: The development of improved methods of fertility regulation, including the improvement of contraceptive technology and the control of infertility; studies of biologic and genetic implications of contraceptive use; and investigations of the social science aspects of population problems.

In services, the plan projected as its goal making family planning services available by 1975 to the estimated 6.6 million women who wanted such services but could not afford them.

In training, the plan estimated 90,000 family planning personnel would be needed by fiscal year 1975, and in addition 6,000 to 8,000 physicians.

In education, the plan defined the goal as an educational program which would help individuals to plan their families effectively and to be aware of the effects of population change on the individual and on society.

ACHIEVING 5-YEAR PLAN GOALS

Mr. President, to date, we have not made enough headway in the research field. Today, there is as yet no completely safe and effective means of contraception available to any woman, rich or poor. Research is urgently needed to develop a means of voluntary control of reproduction. There is much scientific opinion that the technology is there to make this breakthrough if adequate funding is provided.

In the field of education, some steps have been taken to assess the information development and dissemination resources available, but sufficient staff and budget have not been made available to the Office of Population Affairs to really make a perceptible impact on the expansion of such programs or the development of new ones.

In the field of services, Mr. President, organized programs receiving support under the authorities of title X have developed the capacity to reach some 45 percent of HEW's announced objective of reaching 6.6 million women who want family planning services, but are unable to afford them. The Department estimates that by June of this year, only 2,981,000 women will be reached through organized family planning programs. This is a level approximately 1 year behind the projection in the 5-year plan.

In the field of training, Mr. President, nearly 5,000 personnel were trained in fiscal year 1972 as a result of funds made available through the National Center for Family Planning Services. This is a beginning, but unless this program is given increased attention and emphasis it will not be able to achieve the objective that has been set in the 5-year plan to train a total of 98,000 individuals by 1975.

PROVISIONS OF S. 1708

The legislation we are introducing today—S. 1708—extends and consolidates the provisions of the Family Planning Services and Population Research Act of 1970 and generally approves and tightens up its provisions to more clearly reflect the original Congressional intent in the 91st Congress, and to insure that programs can be implemented in accordance with this intent.

In general, the bill would consolidate the provisions of the existing title X of the Public Health Service Act with the provisions of Public Law 91-572, the Family Planning Services and Population Research Act of 1970. This consolidation places in the Public Health Service Act the statutory authority for reports on implementation and achievements of the programs mandated by that title, as well as the organizational structure of the Office of Family Planning and Population Science, to be headed by an Assistant Secretary rather than a deputy assistant secretary. The functions and responsibilities of the Assistant Secretary are clearly defined, and two centers are established directly under his office—a National Center for Family Planning Services, and a National Center for Population Science—with directors appointed by the Assistant Secretary.

In addition, a National Advisory Council on Family Planning and Population Science is established which would exercise peer review authority on research programs supported in the fields of human reproduction, the provision of family planning services, and population dynamics, and would make recommendations with respect to the establishment of policies and implementing regulations to carry out all the provisions of title X, as it would be amended by S. 1708.

The grant and contract authorities currently in title X are maintained with the exception of the State formula grant provision for services, which has never been funded and has been opposed by the administration. Appropriations authorizations for the four programs—services, research, training, and education—are extended for 3 fiscal years, through fiscal year 1976 with modest increases in the amounts authorized. In each case, congressional intent is clearly stated as to the necessity of implementing these appropriations, authorities, and for the purpose of carrying out the objectives in the 5-year plan and its updates.

New requirements are added which will safeguard the rights of individual recipients of services, encourage the provision of family planning services as part of comprehensive child and maternal services, include infertility services as a specific service for which support may be provided, and require the participation of those individuals served by the programs to participate in the decision-making process of such programs.

Also, the requirements for the 5-year plan are revised and refocused, an amended plan to meet these requirements is mandated, and the information to be included in the annual updated reports is specified with greater particularity. Finally, to try to insure a more timely submission of the plan and annual updates—which have traditionally been presented months after they were due by law—the bill calls for submission to the Congress of the version submitted by HEW to the Office of Management and Budget, and places statutory responsibility for preparation and submission directly on the Assistant Secretary.

Mr. President, the Special Subcommittee on Human Resources, which I am privileged to chair, of the Labor and Public Welfare Committee will hold hearings on S. 1708 and Federal family planning and population research programs next week on Tuesday, Wednesday and Thursday, May 8-10.

Mr. President, I ask unanimous consent to insert in the RECORD at this point a summary of the individual provisions of S. 1708, to be followed by the full text of the bill.

There being no objection, the summary and the bill were ordered to be printed in the RECORD, as follows:

SUMMARY OF PROVISIONS OF S. 1708: THE FAMILY PLANNING SERVICES AND POPULATION RESEARCH AMENDMENTS OF 1973

SEC. 1000. Declaration of Purpose. Establishes as purposes of the title, assistance in: making comprehensive voluntary family planning services readily available to all persons desiring such services; strengthening domestic research in the fields of human reproduction, the provision of family planning services, and population dynamics; improving administration and operation of such programs; developing and making readily available information on family planning services and population dynamics; evaluating and improving the effectiveness of programs; providing trained manpower to effectively carry out such programs; and establishing an Office of Family Planning and Population Science.

SEC. 1001. Plans and Reports. Requires the Assistant Secretary for Family Planning and Population Science to report (through the Secretary) to Congress not later than six months after enactment of the section on: the number of individuals in need of family planning services—organized and otherwise—and a timetable for serving them, the number who can be served by HEW programs, the types of information and educational materials to be developed, research goals to be established and a timetable for their achievement, and the manpower required to meet these objectives, as well as steps taken to maintain the reporting system which would yield data on which service projections and program evaluations will be based. This revised report would also include the January 1, 1974, updated report pursuant to section 5(b) of Public Law 91-572. In addition to the report required six months after the date of enactment, the Assistant Secretary is required to submit progress reports annually on specific achievements made in reaching goals established by the six-month report.

SEC. 1002. Voluntary Family Planning Services Grants and Contracts. Authorizes grants to assist in the establishment and operation of voluntary family planning programs and projects. Appropriations are authorized for an additional three-year period—fiscal years 1974 (\$159.5 million), 1975 (\$207.5 million) and 1976 (\$255.5 million). The increase in authorization of appropriations for each year (over the current \$111.5 million—of which \$107 million was requested in the President's FY 1973 budget) represents the cost of providing services to the approximately 800,000 additional individuals the Department's five-year plan for family planning services (submitted pursuant to P.L. 91-572) projected will have to be served each year in order to meet by 1975 the five-year goal of reaching 6.6 million women from low-income families desiring services.

This section would further change existing law by specifying that grants and contracts awarded under this section must be made with the concurrence of the Assistant Secretary for Family Planning and Population Science and be carried out through the new National Center for Family Planning Services in the Assistant Secretary's Office and in consultation with the new National Ad-

visory Council established by new section 1009. Language is also added clarifying that in determining the relative need of the applicant, the Secretary shall take into consideration the availability of third party payments to finance services, but only to the extent that the Secretary determines that the applicant has, in the past, been able to obtain such payments on a timely and continuing basis.

In addition, the section is amended to specify that the amount authorized to be appropriated for the grant and contract authority is to meet the objectives set forth in the revised and updated plan submitted by the Secretary pursuant to section 1001.

SEC. 1003. Training Grants and Contracts. Extends appropriations authorizations for an additional three-year period—fiscal years 1974 (\$5 million), 1975 (\$7.5 million), and 1976 (\$10 million)—for training grants and contracts for the training of such personnel to carry out family planning services programs eligible for support under title X as are needed to meet program objectives specified in the plan. The FY 1973 authorization and budget request are \$4 million and \$3 million, respectively, for this item. This section would, again, amend existing law by specifying that grants and contracts awarded under this section must be made with the concurrence of the Assistant Secretary for Family Planning and Population Science and be carried on through the new National Center for Family Planning Services and in consultation with the new National Advisory Council. The necessity of training nurse midwives to carry out family planning services programs is also stressed.

In addition, existing law is changed to specify that the amount authorized to be appropriated for the grant and contract authority is to meet the objectives set forth in the revised and updated plan submitted by the Secretary, and that in determining the amount of funds to be provided under any grant or contract, the Secretary shall ensure that assistance under title X is provided only to the extent such training is not supported by a sufficient amount of Federal assistance under other titles of the Public Health Service Act or other provisions of law. The section further requires the Assistant Secretary to concur in the awarding of any grants for the training of personnel in the field of family planning which training would be authorized under this section.

SEC. 1004. Research Grants and Contracts. Extends appropriations authorizations for an additional three-year period—fiscal years 1974 (\$65 million), 1975 (\$75 million) and 1976 (\$80 million)—for grants and contracts for research in biomedical, contraceptive development, social science and program implementation fields related to family planning and population dynamics. The present FY 1973 authorization is \$65 million. The FY 1973 budget includes \$39.8 million for contraceptive development carried out under the National Institute for Child Health and Human Development, not under title X. To remedy this, the section also gives the Assistant Secretary authority to utilize any other population research authority and appropriations thereunder to carry out research goals under this section. Any Federal support for contraceptive development research carried out by a profit-making entity is limited to 50 per cent of the total cost of such research. This section would, again, amend existing law by specifying that grants and contracts awarded under this section must be made with the concurrence of the Assistant Secretary for Family Planning and Population Science and carried out through the new National Center for Population Science and after peer-review consultation with the new National Advisory Council. In addition, the section would change the existing law to specify that the amount authorized to be appropriated for the grant and contract authority is to meet the objectives set forth in the revised and updated plan submitted by the Secretary. Grants for the establishment of university-based research centers are stressed.

SEC. 1005. Informational and Educational Materials Grants and Contracts. Extends appropriations authorizations for an additional three-year period—fiscal years 1974 (\$1.5 million), 1975 (\$2 million) and 1976 (\$3 million)—for grants and contracts for information and educational materials on family planning and on the causes and consequences of demographic characteristics and trends, as well as for the distribution of such materials. The present FY 1973 authorization is \$1.25 million and \$700,000 is included in the FY 73 budget. The section gives the Assistant Secretary authority to sign off on population education or information assistance provided under any other law which would be authorized under this section. This section would, again, amend existing law by specifying that grants and contracts awarded under this section must be made with the concurrence of the Assistant Secretary for Family Planning and Popu-

lation Science in consultation with the new National Advisory Council. The section would also change existing law to specify that the amount authorized to be appropriated for the grant and contract authority is to meet the objectives set forth in the plan submitted by the Secretary.

SEC. 1006. Regulations, Payments, and Special Conditions. Requires projects or programs receiving assistance under section 1002 to be located so as to be most accessible to persons from low-income families rather than to express this thought as a priority to low-income persons in the provision of services, as in present law. The section also prohibits charges for such services except to the extent that payment will be made by a third party, and requires wherever feasible, such projects or programs to make arrangements, either directly or through linkages, for a comprehensive range of child and maternal health services, including infertility services, to individuals to whom family planning services are made available. The section further requires that those persons served by such projects and programs participate in the decision-making process for such projects or programs; requires opportunity for review and (non-binding) comment by the 314 (a) and (b) (comprehensive health planning) agencies on applications for family planning services support under section 1002; prohibits research programs involving human subjects at risk unless projects or programs have assured the Secretary that the rights and welfare of any individuals involved are fully protected; and limits provision of drugs to individuals for only those uses indicated in the official labeling of such drugs approved by the Food and Drug Administration (except in the case of the use of investigational new drugs where such use is in compliance with requirements prescribed by the Secretary, or where use for another purpose is approved by a peer review committee in accordance with regulations prescribed by the Secretary, or where two physicians certify that such use is necessary in a life-threatening situation). The term "low-income family" is defined as the Department of Labor lower living standard budget (\$7,214) and the questioning of any individual as to his income level is prohibited in services projects and programs assisted under title X. Finally, a State health authority in order to receive support under section 1002 is required to submit a statewide plan for a comprehensive program of family planning services, with requirements for subsequent periodic reporting on achievement in reaching goals outlined in the plan.

SEC. 1007. Voluntary Participation. Requires that acceptance of any service or information provided through financial assistance under title X must be on a totally voluntary basis and cannot be made a condition for the receipt of any other service or benefit. (Identical to the present title X language.)

SEC. 1008. Prohibition of abortion. Prohibits use of funds under title X in programs where abortion is a method of family planning. (Identical to the present title X language.)

SEC. 1009. Office of Family Planning and Population Science. Establishes within the Office of the Secretary of HEW an Office of Family Planning and Population Science, to be directed by an Assistant Secretary for Family Planning and Population Science appointed by the President by and with the advice and consent of the Senate, and establishes within the Office of Family Planning and Population Science a National Center for Family Planning Services (currently existing in the Health Services and Mental Health Administration in HEW) and a National Center for Population Science (currently existing in the NIH Institute of Child of Health and Human Development). The section also establishes a National Family Planning and Population Science Advisory Council consisting of the Secretary, the Assistant Secretary, the Directors of the two new Centers, and fifteen (eight technical/scientific/programmatic and seven general public) members appointed by the Secretary. Functions of the Council shall be to advise, consult with, and make (peer-review-type) recommendations to the Secretary on applications for grants and contracts for research under section 1004, and to make recommendations to the Secretary with respect to the establishment of policies and implementing regulations to carry out all the provisions of title X, including the preparation and review of the annual budget estimate for all programs under title X, and of the plan and reports required by title X.

Sec. 1010. Functions of the Assistant Secretary for Family Planning and Population Science. Requires the Secretary to utilize the Assistant Secretary: to administer and be responsible for grants and contracts related to family planning services and research in the fields of human reproduction, the provision of family planning services, and population dynamics, including training of necessary manpower for such programs and evaluation of all such programs; to concur in the operation of programs providing any other Federal assistance for such purposes (including consultation with the FDA Commissioner on the testing, evaluation and approval of contraceptive methods under the Federal Food, Drug and Cosmetic Act); to act as a clearinghouse for information pertaining to such programs; and to provide liaison with activities carried on by other agencies of the Federal Government relating to such programs. The Assistant Secretary is also given responsibility for preparing the budgets for carrying out the programs of the National Center for Family Planning Services and the National Center for Population Science, as well as the responsibility for appointing the Directors of such Centers.

Miscellaneous provisions amend Public Law 91-516, the Environmental Education Act, to add the Assistant Secretary as a member of the Advisory Council on Environmental Education; and to require, wherever feasible, that grants or contracts supported under that Act include programs for consideration of the relation of population to the total human environment and require that grants and contracts including such a component or any other component related to population education have the concurrence of the Assistant Secretary.

93d CONGRESS
1st Session

S. 1632

IN THE SENATE OF THE UNITED STATES

APRIL 18, 1973

Mr. JAVITS (by request) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To extend for three years the programs for comprehensive State and areawide health planning, and for comprehensive public health service and health services development, and to repeal a requirement that at least 15 per centum of a State's formula allotment for public health services be available only for mental health services.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*
 3 That (a) sections 314 (a) (1), 314 (b) (1) (A), 314 (d)
 4 (1), and 314 (e) of the Public Health Service Act are each
 5 amended by inserting “, and such sums as may be necessary
 6 for each of the next three fiscal years” after “for the fiscal
 7 year ending June 30, 1973”.

8 (b) The first sentence of section 314 (b) (1) (A) of

1 such Act is amended by striking out "and ending June 30,
2 1973" and inserting in lieu thereof "and ending June 30,
3 1976".

4 SEC. 2. Effective with respect to appropriations for fiscal
5 years beginning after June 30, 1973, section 314 (d) (7)
6 of such Act is repealed.

[From the Congressional Record—Senate, Apr. 18, 1978]

(By Mr. Javits)

S. 1632. A bill to extend for 3 years the programs for comprehensive State and areawide health planning, and for comprehensive public health service and health services development, and to repeal a requirement that at least 15 per centum of a State's formula allotment for public health services be available only for mental health services. Referred to the Committee on Labor and Public Welfare.

EXTENSION OF PARTNERSHIP FOR HEALTH

MR. JAVITS. Mr. President, I am introducing at the request of the administration a bill to extend, with some modifications sections 314(a), 314(b), 314(d), and 314(e) of the Public Health Service Act for 3 years.

314(a) AND 314(b)

Secretary Weinberger in his letter of transmittal states:

"Although we propose to extend the legislation under which we foster comprehensive State and areawide health planning, we do so with awareness that the comprehensive health planning system is beset with weaknesses that interfere with its effectiveness."

He further says:

"Moreover, Federal implementation of program requirements has not been effective to assure an open public planning process or consumer participation in that process. The degree to which some CHP agencies are accountable to the local public has therefore been compromised."

The Secretary's stated concern that the comprehensive health planning system is afflicted with some weaknesses that interfere with its effectiveness is shared by the Congress. It was a motivating factor in limiting CHP extension under the recent Senate passed omnibus extension of expiring PHS programs (S. 1136) to 1 year. I am concerned that by proposing a 3-year CHP renewal, the administration suggests that instead of Congress working its will in improving and rationalizing CHP the Congress rely upon HEW's ability to, and I quote:

"Allow us to improve and redirect CHP through greatly improved management."

I believe it would be more appropriate for the administration to send up a legislative proposal which seeks to assess ways in which the planning process can impact most favorably on the health care system and determine the potential applicability to CHP on a national basis of the activities now under way in various States with regard to facility certificate-of-need and rate setting procedures. I believe that Congress would welcome the opportunity to work together to attain that desirable goal. Let us work together in overcoming CHP weaknesses, building upon CHP strengths, and thus improve State and regional capacity to conduct effective health planning.

314(c)

I am also concerned that the bill does not seek an extension of the program of project grants, contained in section 314(c) of the Public Health Service Act, for training, studies, and demonstrations in the health planning field. The Secretary charges:

"Our experience with these grants is that they have not contributed materially to the overall competence of the health planning process."

He also alleges persons who wish to pursue graduate training in health planning can be assisted through alternative sources, suggesting that there is available the student assistance programs of the Office of Education. When the allegations are proven and the evidence is in regarding alternative financial resources, will be a better time for decision on the merits of repealing section 314(c).

314 (d)

I am also concerned that the bill, while extending the 314(d) program of grants for comprehensive public health services, repeals the provision that earmarks 15 percent of a State's allotment for State mental health agencies for the provision of mental health services. I do not know of data which would convince me that some States may not seek to escape their responsibilities to their mentally ill citizens. Unfortunately, this is all too often the case.

314 (e)

My deepest concern, however, is the administration's view in support of the extension of the authority to make project grants for health services development, section 314(e) of the Public Health Service Act. The administration proposes to consolidate support for the other health service programs under this authority, rather than continuing other congressional health program authorizations. Examples are migrant health activities, population research and family planning programs, and lead-based paint poisoning research and control efforts. In essence, a determination to utilize section 314(e) of the Public Health Service Act for funding programs the Executive chooses to support. I am concerned that the Executive has failed to recognize what Congress has made crystal clear in regard to such proposed action. Only last year, the Congress passed and the President signed into law, Public Law 92-449. The legislative history of section 314(e) is enunciated in Senate report 92-285, where in discussing this section of the law, it cites the House Committee on Interstate and Foreign Commerce in its report on the Communicable Disease Control Amendments of 1970:

"In each of its budget presentations each year since the enactment of section 314(e), the Department of Health, Education, and Welfare has earmarked specific amounts of the 314(e) fund request for specific programs for the coming year. In other words, the categorical grant approach has continued since the enactment of Public Law 98-749, except that instead of the Congress setting the categories, the categories have been set by the Department of HEW."

I believe we must restore some control to Congress of the categories of health programs for which project grant funds are to be made available.

The Senate Labor and Public Welfare Committee in respect to this matter in its report on the Health Services Improvement Act of 1970 stated:

"The Committee notes with concern the fact that a large proportion of the programs funded under section 314(e) continue to be too narrowly focused rather than focused upon the broader area of the organization and delivery of health services."

I ask unanimous consent that the letter of transmittal and a copy of the bill be printed in the **RECORD**.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MAR 29 1973

Honorable Spiro T. Agnew
President of the Senate
Washington, D. C. 20510

Dear Mr. President:

We enclose for the consideration of the Congress a draft bill "To extend for three years the programs for comprehensive State and areawide health planning, and for comprehensive public health service and health services development, and to repeal a requirement that at least 15 per centum of a State's formula allotment for public health services be available only for mental health services."

The effect of the bill is described in its title. Although we propose to extend the legislation under which we foster comprehensive State and areawide health planning, we do so with awareness that the comprehensive health planning system is beset with weaknesses that interfere with its effectiveness. One significant problem with comprehensive health planning, for example, is that the legislation and the accompanying rhetoric have articulated very ambitious missions which, by and large, the CHP system has been unable to carry out. Moreover, Federal implementation of program requirements has not been effective to assure an open public planning process or consumer participation in that process. The degree to which some CHP agencies are accountable to the local public has therefore been compromised.

Despite the widespread disenchantment with the CHP system that these problems, among others, have engendered, the evidence is persuasive that unconstrained health resource development, particularly of inpatient facilities,

contributes significantly to the problem of excessive and unnecessary increases in health care costs. The lack of effective competition, the dependence of patients on the judgment of their physicians regarding their health care needs (and the consequent capability of supply to generate its own demand), the predominance of cost reimbursement as a means of paying for institutional health care services, and pressures for institutional aggrandizement in a non-competitive economy, combine to offset normal competitive constraints on building surplus capacity. Thus, unless or until reasonably effective competition is established, there is a need to maintain some effective control over construction or expansion of health care institutions.

On balance, we conclude that, given the broad authority in current law, new legislation is not needed to overcome the weaknesses in the present system. We propose, instead, to extend current law for a period sufficient to allow us to improve and redirect CHP through greatly improved management. A plan for this management approach is currently under review within the Department. This plan for improved management of the program will be based on a serious evaluation of the strengths and weaknesses of the existing CHP agencies and will seek to assess ways in which the planning process can impact most favorably on the health care system. We expect to study carefully the potential applicability to CHP on a national basis of the activities now under way in various States with regard to facility certificate-of-need and rate setting procedures.

This extension does not imply that the Federal Government should support health planning agencies indefinitely. In the final analysis, if comprehensive health planning does not succeed in demonstrating its value to State and local government officials we do not believe it should be perpetuated indefinitely as a Federal responsibility. The

seriousness of the problems in the health care system, however, are such that we believe that efforts to improve State and regional capacity to conduct effective health planning merit Federal support at this time.

In proposing to extend the program of grants for comprehensive public health services (section 314(d) of the Public Health Service Act) we ask the repeal of the provision that earmarks 15 per cent of a State's allotment for State mental health agencies for the provision of mental health services. This limitation on the latitude of a State to apply its formula grant to meet what the State, not the Federal Government, perceives to be the State's priority health needs is inconsistent with the original and continuing objectives of Partnership for Health.

The bill would also extend the authority contained in section 314(e) of the Public Health Service Act to make project grants for health services development. This is a broad, flexible authority, well suited to continue and improve the support of migrant health and population research and voluntary family planning programs now assisted under the narrow categorical authorities contained, respectively, in section 310 and title X of the Act. We have therefore not proposed extension of these latter categorical authorities.

We are not seeking extension of the program of project grants, contained in section 314(c) of the Public Health Service Act, for training, studies, and demonstrations in the health planning field. Our experience with these grants is that they have not contributed materially to the overall competence of the health planning process. Persons who wish to pursue graduate training in health planning can be assisted through alternative sources, e.g., the student assistance programs of the Office of Education, which are available generally to all deserving students in higher education.

Honorable Spiro T. Agnew

4

We urge the Congress to give our proposal its prompt and favorable consideration.

The Office of Management and Budget advises that enactment of this proposed legislation would be in accord with the program of the President.

Sincerely,

/s/ Casper W. Weinberger

Secretary

Enclosure

A B I L L

To extend for three years the programs for comprehensive State and areawide health planning, and for comprehensive public health service and health services development, and to repeal a requirement that at least 15 per centum of a State's formula allotment for public health services be available only for mental health services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) sections 314(a) (1), 314(b) (1) (A), 314(d) (1), and 314(e) of the Public Health Service Act are each amended by inserting ", and such sums as may be necessary for each of the next three fiscal years" after "for the fiscal year ending June 30, 1973".

(b) The first sentence of section 314(b) (1) (A) of such Act is amended by striking out "and ending June 30, 1973" and inserting in lieu thereof "and ending June 30, 1976".

Sec. 2. Effective with respect to appropriations for fiscal years beginning after June 30, 1973, section 314(d) (7) of such Act is repealed.

Senator CRANSTON. We will now proceed with the witnesses. Our principal witness today is Dr. Henry Simmons, Deputy Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare.

He is accompanied by Dr. Louis Hellman, Deputy Assistant Secretary for Population Affairs; also by Dr. Carl Shultz, Director, Office of Population Affairs; Philip Corfman, M.D., Director, Center for Population Research, National Institute of Child Health and Human Development, National Institutes of Health, DHEW.

We are delighted to have you with us.

STATEMENT OF HENRY E. SIMMONS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DHEW, ACCOMPANIED BY LOUIS M. HELLMAN, M.D., DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS, DHEW; CARL SHULTZ, M.D., DIRECTOR, OFFICE OF POPULATION AFFAIRS, DHEW; AND PHILIP CORFMAN, M.D., DIRECTOR, CENTER FOR POPULATION RESEARCH, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, NATIONAL INSTITUTES OF HEALTH, DHEW

Dr. SIMMONS. Thank you, Mr. Chairman.

It is a pleasure to be here today to discuss S. 1708, the "Family Planning Services and Population Research Amendments of 1973."

Mr. Chairman, the administration opposes S. 1708. On April 18, 1973, the administration's bill, S. 1632, "The Comprehensive Health Planning—Partnership for Health Amendments of 1973", was introduced. This legislation was introduced by Senator Javits. We strongly recommend the enactment of S. 1632 rather than S. 1708. I will discuss the detailed basis for our opposition to S. 1708 later, but I would first like to review the framework within which the administration's policies should be viewed.

Both Congress and the President have emphasized the role of family planning in enabling individuals to obtain the health, economic, and social benefits which accrue from voluntarily controlling their fertility. President Nixon has stressed that family planning services should be available to all those who want but cannot afford them.

Within this policy framework, the administration believes that the proper Federal role, in family planning as in other health areas, is one of support, not domination. In the long run, the proper Federal role in family planning is the same as in health services delivery generally, that is, to reduce financial barriers to health services.

The principal resources for accomplishing this will be the medicaid program and the administration's proposals for national health insurance which will soon be submitted to the Congress.

We believe that the efforts to date have clearly demonstrated the value of family planning services. We support the policy reflected in Public Law 92-603, "The Social Security Act of 1972" that responsibility for financing these services on a "needs" basis be part of Federal, State, and local efforts primarily through medicaid. Public agencies at the State and local level will be encouraged by Public Law

92-603 to discharge their responsibilities and to assure that private initiative and resourcefulness are given the opportunity to serve the health needs of those needy desiring family planning services.

In summary, we believe that growth in family planning efforts should take place through the equitable financing programs rather than through the categorical program authorities of the past.

Progress toward nationwide coverage has been rapid. At the end of fiscal year 1972, some organized family planning services were available in 2,379 of the 3,099 counties, parishes, and districts in the United States. An estimated 90 percent of low-income women who might require subsidized services live in these counties.

The 720 counties shown to be without services available are mainly rural and contain less than 10 percent of the women who might need subsidized services. These county statistics indicate that considerable progress has been made in providing subsidized family planning services in most areas of the country.

Progress toward providing family planning services to all women who desire but cannot afford them is difficult to measure since many variables affect the number of women defined as requiring subsidized services. Such factors include population shifts, changing income levels, and variations in desired family size. The number of women of childbearing ages 15 to 44 who might need financial assistance in fiscal year 1975 ranges from 3,432,000 at the poverty level to 6,582,000 at 150-percent-of-poverty level.

Estimates must be revised periodically to reflect changes in the variables. Special 1970 census tabulations of U.S. women aged 15 to 44 stratified by marital status and income level have been ordered. These statistics when available in 1973, are expected to show fewer women in the poverty categories.

The Federal Government, by subsidizing organized family planning services has assisted in the development of the capacity to serve individuals who need assistance in obtaining such services.

As I mentioned earlier, recent Federal legislation has made family planning services a mandatory element of State medicaid plans. Under medicaid, States determine the eligibility with Federal requirements. An estimated 3.2 million low-income individuals, however, were served by organized programs and private physicians in fiscal year 1972, of which 2 million were served by organized programs and about 1.2 million by private physicians not associated with the organized programs.

In fiscal year 1971, nearly 800,000 new patients were enrolled in organized clinic programs and the partial service statistics available for fiscal year 1972 indicate that the number of new enrollees in 1972 may have exceeded the 838,000 projected. The proportion of women served by private physicians is expected to increase during the next 3 years as a result of numerous factors—greater information about, and legitimization of, family planning; removal of remaining legal and administrative barriers to family planning services; the trend toward public and private third-party reimbursement mechanisms to finance family planning care; and increased referral of patients to private physicians by organized programs.

Organized family planning services are provided by public and voluntary hospitals; State, county, and local health departments;

voluntary agencies, and other organizations. In fiscal year 1971, voluntary and other agencies served 41 percent of reported patients, health departments 36 percent, and hospitals 23 percent.

Information based on contact with 1,653 current providers showed that nearly all current provider agencies served more patients in fiscal year 1972 than in fiscal year 1971 and more than one-third of current providers expected their programs to continue growing in fiscal year 1973. The reason most often mentioned for growth was increased demand for services. Almost half of the potential providers were interested in providing subsidized family planning services.

The national reporting system of family planning services has made it possible to evaluate the extent which the program provides fertility related preventive health care and entry into the health care system. Analysis of nearly 800,000 patient records for calendar year 1971 indicated that more than 90 percent of individuals receiving services chose the most effective methods of contraception. The methods chosen were: oral contraceptive, 73 percent; intrauterine device, 18 percent; jelly/cream/foam, 4 percent; diaphragm, 2 percent; other, 3 percent.

Studies have shown that the use-failure rates of pills and IUD's are only one-fourth to one-seventh as high as for other methods. The function of the organized program in facilitating use of the more effective methods by young low-income couples is thus important from health, social and demographic perspectives.

Patients also received significant preventive health services. These included: a medical exam or at least one laboratory test, 94 percent; pelvic examination, 88 percent; breast examination, 77 percent; other medical examinations, 54 percent; Pap smear, 79 percent; other laboratory tests, 60 percent.

All elements in the family planning delivery system appear to provide a high level of diagnostic health care to patients. Since over 2 million are receiving subsidized services through organized family planning programs, they have become a major—perhaps the major—source of preventive health care for young, low-income, and largely women of childbearing age.

Data from various reporting systems covering 1.1 million patients indicate that women currently being served in organized family planning programs are young (median age is 23, and five out of six are under 30). Eighty percent have three children or less, and 30 percent have had no children. More than 50 percent are high school graduates and about 16 percent receive public assistance.

The National Center for Family Planning Services project grants program has grown markedly from 80 grants and \$12 million of obligations at its inception in fiscal year 1969 to an estimated 300 grants and \$98.5 million of obligations in fiscal year 1973. During this time, about 250 OEO projects with operating costs of \$20 million have been transferred to NCFPS and the remaining OEO projects and funds will be transferred to NCFPS in fiscal year 1974. To improve program coordination many of these projects, as well as ongoing NCFPS projects have been consolidated into areawide or statewide grants. Over 200 grants have been consolidated, holding the total number of grants to about 300, rather than a much larger number which would exist otherwise. The Center will continue to encourage grant consolidations which improve services and reduce administrative costs. Projects re-

ceiving support from NCFPS are expected to provide services to 1.9 million individuals in fiscal year 1974.

Nearly 5,000 personnel were trained in fiscal year 1972 with NCFPS funds. This training is provided through short-term training programs. Training grants total about \$2 million and training contracts totaled about \$1 million in fiscal year 1972. Grants funds support regional and areawide training centers while contract funds support special training projects.

In addition to two major regional training centers, a number of training centers have been developed at the State level specifically tailored to the needs of the individual States.

The Office of Information and Education, NCFPS, provides leadership to national family planning information and education activities, initiates special efforts to improve the quality of materials used in the field, communicates with health and social organizations in the Federal and private sectors to assure their understanding of family planning goals, and evaluates information and education programs throughout the country.

In 1968 Congress established an authorization for family planning services under title V of the Social Security Act. Primary responsibility for administering title V is vested in the Maternal and Child Health Service (MCHS) within HSMHA. Title V requires that not less than 6 percent of the amounts appropriated for maternal and child health services formula grants, project grants, and research and training be obligated for family planning services. The amounts obligated under this authority have always exceeded the 6 percent minimum. Fifty-four maternity and infant care (M. & I.) projects provide family planning services to high-risk prospective mothers. These M. & I. projects provided family planning services to over 120,000 individuals in fiscal year 1972, and MCHS formula grants helped support family planning services for an additional 860,000 individuals in the same year.

The passage of Public Law 92-603, the "Social Security Amendments of 1972," established a major incentive for States to provide family planning services. Prior to the passage of these amendments, the provision of family planning services was a State option. However, Public Law 92-603 makes it mandatory that States inform all present and certain former or potential recipients of "Aid to Families With Dependent Children (AFDC)" who are of childbearing age of the availability of family planning services.

The act imposes a penalty of 1 percent per annum on the Federal share of AFDC funds on States which failed to provide these services in the previous year to eligible persons desiring them.

In addition, the act increased the Federal share of matching for family planning services under title IV-A-AFDC—to 90 percent from 75 percent and increases the Federal share for family planning services under title XIX—medicaid—to 90 percent from a variable formula with a range from 50 to 83 percent Federal matching.

The 1972 amendments to the Social Security Act expand the universe of persons to whom family planning services are offered since they include applicants for, as well as recipients of, public assistance, as well as minors who are considered to be sexually active.

State and local agencies have been working to develop cooperative relationships with public and private providers of medical services.

The emphasis in the 1972 amendments to the Social Security Act on the immediate provision of family planning services to those desiring them should assure continuation of efforts to develop additional medical resources.

The 1972 Social Security Act amendments made the provision of family planning services to cash assistance recipients under title XIX mandatory on the States. Medical assistance for family planning includes payments for appropriate medical examinations, diagnosis, medical counseling and treatment, laboratory services, surgical procedures, drugs, supplies, and devices. These services may be provided in doctor's offices, clinics, hospitals (on both an inpatient and outpatient basis), family planning centers, or any other suitable setting.

Because of the increased responsibility placed on the State agencies to assure that family planning services are offered to all eligible persons who wish to utilize them, and because of the increased Federal matching, substantial increases are expected in title XIX expenditures.

The Department of Health, Education, and Welfare is encouraging the States to make use of the SSA title XIX mechanism as the principal source of financial support for family planning services.

In the absence of effective medical family planning efforts, categorical grants have in the past been useful in reducing financial barriers that limit access of low-income individuals to needed health care. Existing programs, currently receiving project grants, are being encouraged to utilize third-party payment mechanisms as their principal source of financial support.

Now that these programs are firmly established, financing should shift from project grant programs administered by the Federal Government to the medicaid program in which States assume the major role in determining program needs in their area.

Therefore, the administration has included increased estimates for medicaid in the 1974 budget request. This increase in Medicaid funds will assist the States in implementing their medical assistance plans to low-income individuals. The individual State plans will determine the goals and priorities for family planning services within each of the States, and the aggregates of these goals and priorities will constitute the national program.

The Social and Rehabilitation Service administers the Social Security Act titles IV-A and XIX which support family planning services for low-income individuals. These services are designed to promote health, reduce out-of-wedlock pregnancies, and enable State welfare agencies to carry out their responsibilities in work-training and employment programs for AFDC recipients.

Included in these services are targeted programs of research and demonstration projects in family planning. Title IV-A assists States in developing plans and administering programs for family planning services. All States and jurisdictions, with one exception, have fulfilled the title IV-A requirements of the 1967 amendments to the Social Security Act to provide for the offering of family planning services in all appropriate cases and to assure that acceptance of family planning services is voluntary.

Family planning social services include the provision of information, personal counseling, medical services, payment for medical services, referral for medical care, follow-up of medical referrals,

provision for transportation and child care arrangements so that parents may obtain family planning services.

In the population research area, both the Congress and the President have emphasized the importance of a strong Federal role. In his July 1969 message to Congress, President Nixon called for Federal action to solve population problems. He said:

* * * increased research is essential. It is clear . . . that we need additional research on birth control methods of all types and the sociology of population growth. Utilizing its Center for Population Research, the Department of Health, Education, and Welfare should take the lead in developing, with other Federal agencies, an expanded research effort, one which is carefully related to those of private organizations, university research centers, international organizations, and other countries.

The mission of population research is to develop methods of fertility regulation which are safe, effective, and likely to be used, and to understand the motivation for their use. Within the Department of Health, Education, and Welfare, the Center for Population Research (CPR) of the National Institute of Child Health and Human Development (NICHD) has the primary responsibility for research efforts to improve contraceptive technology and to increase understanding of the biological and behavioral aspects of population growth and change.

Research strategy in the NICHD contraceptive development program requires: drug development and testing, development of new or improved contraceptive devices and systems, and directed biomedical research in targeted areas. Two examples of progress in the area of contraceptive development during fiscal year 1972 are:

1. Synthesis of 4.0 grams of hypothalamic releasing factor for distribution to scientists, thus providing the major low-cost source of this significant and promising regulatory factor. With this quantity of substance available, investigators will be able to evaluate its significance for fertility regulation; and

2. Synthesis of a number of prostaglandin analogues, one of which does not stimulate smooth muscle, thus separating the abortifacient action from other potential antifertility effects. It will now be possible to determine if those other antifertility effects have potential for the development of new contraceptive agents.

A second type of biomedical research supported by the NICHD is fundamental biomedical research. Most of the fundamental research in reproductive biology conducted in this country is supported at least in part by the NICHD. The increased knowledge of reproductive processes resulting from the work is essential for achievement of the Institute's program goals. An example of progress in this area during fiscal year 1972 is the development of a test sensitive enough to detect pregnancy as early as 5 days after fertilization, making pregnancy detectable 3 weeks earlier than previously possible.

The third biomedical research activity of the NICHD is contraceptive evaluation. Although this program monitors the medical effects of all contraceptives currently in use, oral contraceptives have received major emphasis. Secondary efforts have been started on IUD's and vasectomy.

The goals of the NICHD behavioral sciences program are:

1. To ascertain the social, psychological, and economic determinants of fertility; and

2. To expand understanding of the consequences of population growth and change so that public policy may be guided by adequate information.

Underway only 4 years, this program has already made significant contributions, the most notable being the national fertility study. Data from this survey became an integral part of the report of the Commission on Population Growth and the American Future. The survey emphasized investigation of the causes of changes in fertility patterns. One important finding was that unwanted fertility declined 35 percent for whites and 56 percent for blacks from 1960 to 1970. The survey also found that 1 in 6 couples currently chooses sterilization to control fertility.

As part of its efforts in the area of basic research, the NICHD currently supports seven population research centers and nine program projects.

The NICHD has also supported limited activities in the area of manpower development.

Scientific information activities supported by the NICHD include an inventory and analysis of Federal research, an index of biomedical research, and monographs in population research.

As I stated earlier, the administration has recommended that family planning services activities be continued in fiscal year 1974 under the flexible authorities contained in section 314(e) of the Public Health Service Act. This broad, flexible authority is well suited to continue and improve the support of voluntary family planning programs now assisted under the narrow categorical authorities contained in title X of the act.

Under the administration's proposals those ancillary service program activities such as training, services, delivery research, and information and education activities presently conducted under title X authority will be continued under existing authorities.

Population research activities will be continued under title III of the Public Health Service Act. I believe that Congress would agree that it is in the best interest of both the Congress and the administration to consolidate legislative authorities whenever this can be done without adversely affecting operations.

In addition to being duplicative and unnecessary, S. 1708 contains a number of undesirable provisions. I will discuss the major ones.

In contrast to sound organizational principles, S. 1708 would establish by statute a new Office of Family Planning and Population Science within the Office of the Secretary, DHEW. In addition, S. 1708 would require that the proposed office be headed by an Assistant Secretary rather than the Deputy Assistant Secretary authorized by the current legislation.

S. 1708 would also undesirably establish in law two centers within the Office of Family Planning and Population Science. These include a National Center for Family Planning Services (currently existing under the Health Services and Mental Health Administration in HEW) and a National Center for Population Science (currently existing under the NIH Institute of Child Health and Human Development in HEW). Finally, the proposed legislation would also create a National Family Planning and Population Science Advisory Council to advise the Secretary on grants and contracts.

We are strongly opposed to those unnecessary and undesirable organizational proposals for a number of reasons. The proposed organizational pattern would have an adverse effect on program operations. We firmly believe that family planning services and population research programs should remain within the health complex under the direction of the Assistant Secretary for Health in order to assure coordinated, efficient health programs and consistent health policies.

We are also concerned that removing research on biomedical and behavioral aspects of population from the National Institutes of Health would be detrimental to other ongoing and related research activities.

Our experience in biomedical research has shown that there are numerous interconnections among subfields and that contributions from one area of investigation often create tools and stimuli for research in other areas. This is also the case in the services areas. It is essential that family planning services be closely linked to health services and integrated into organized systems for comprehensive health care. Furthermore, the administration believes that no organizational pattern should be established by statute since this unduly restricts the Secretary's responsibility and flexibility to manage and administer programs effectively.

As a whole, rather than simplify program administration, these proposed organizational changes would tend to make the program activities currently conducted more difficult to administer. By creating an additional Assistant Secretary concerned with health programs, S. 1708 represents a step backward from the efforts to improve health program organization recently announced by Secretary Weinberger.

S. 1708 stipulates that if the 5-year plan or subsequent progress reports are reviewed by the Office of Management and Budget or other Federal agencies, the plan submitted should identify the changes made during the review process. In addition, if the report is delayed beyond its submission date, it must be submitted to the Congress in exactly the form it was submitted for review.

The administration strongly objects to the submission of working papers to Congress since such a procedure could only promote confusion and disorderly administration.

The appropriation authorizations contained in S. 1708 are clearly excessive. S. 1708 would authorize appropriations of \$231 million in 1974, \$292 million in 1975, and \$349 million in 1976. This compares to a 1974 budget request of \$122 million. We do not believe that these excessive amounts are necessary to implement an appropriate direct Federal role in family planning activities.

S. 1708 would also require that only funds appropriated by the proposed bill could be used for family planning training, research, and development of educational and informational materials unless the Assistant Secretary for Family Planning and Population Science has concurred in the terms and conditions governing the use of such funds.

This restrictive provision would be administratively cumbersome, and could handicap the kind of interchange between family planning and other health services activities which will lead to the development of the best possible family planning program as well as the widest possible dissemination of family planning knowledge and techniques.

In addition, this requirement could unnecessarily and inappropriately involve this Department in the programs of other agencies, for example, the Defense and the State Departments. We do not believe that this is the bill's intent.

In summary, Mr. Chairman, we oppose S. 1708 for what we regard as sound programmatic and organizational considerations, as outlined above. We strongly oppose the excessive authorization and the continued proliferation of unnecessarily categorical authorizations. Moreover, S. 1708 conflicts with the congressional intent reflected in Public Law 92-603 that the States begin to mount family planning programs aimed at those in need. We believe the direct Federal funding of family planning services should no longer be expanded, but that future reliance be placed on financing efforts. For these reasons we urge the committee to give favorable consideration to S. 1632 rather than S. 1708.

I thank you for the opportunity to meet with you today. We shall be glad to try to answer any questions the subcommittee may have.

Senator CRANSTON. Thank you very much for your testimony.

At this time I must say that I do not plan to ask any questions this afternoon with regard to your testimony on this bill. My sole inquiry will be in regard to the report which has been due from HEW since January 1 updating the 5-year plan.

The reason I am not going to proceed to ask any questions at this time is the failure of the administration to submit its written testimony to the committee 24 hours in advance, as required by rule 9 of the Committee on Labor and Public Welfare.

Members of my staff have repeatedly during the last 2 years stressed the necessity for the subcommittee to receive testimony from witnesses the day before the hearing. In fact, three copies of the testimony were finally delivered at noon today, and there was just no opportunity to really look at them before this hearing began.

The administration failure to comply with this rule of the committee—and this is particularly the case with respect to HEW—generally has been repeated and persistent. It is a situation that I think is rather intolerable, one which makes it exceedingly difficult for the committee through its committee structure to carry out its responsibilities to investigate and consider all aspects of proposed legislation and to oversee the implementation of programs by the executive branch in furtherance of its own constitutional responsibility to faithfully execute the laws.

In this particular instance, in order to provide the administration with as much leadtime as possible to prepare its testimony, I transmitted to the administration 2 weeks ago, on April 14, a committee print of the bill which I subsequently introduced, S. 1708, with very minor changes.

In addition the President's budget was submitted to the Congress on January 29, and the administration's legislative proposal with respect to family planning was transmitted on March 29 of this year. Surely the administration has had more than ample opportunity to prepare a detailed justification of its legislative proposal or the language thereof in sufficient time to comply with the very reasonable rules of the Congress.

Accordingly, I am asking if I may that you make yourselves available either May 18, May 22, or May 23 at a mutually agreeable time,

during which it is my intention to pursue with you questions raised by your prepared testimony or questions which were not answered in your prepared testimony, after members of the subcommittee have been given the opportunity to evaluate intelligently the testimony of the administration.

I know that the individuals present here this morning on behalf of the administration have worked very hard to prepare this testimony. I want to acknowledge that fact. I want also to say that I have deep respect for the program leadership of Dr. Hellman and Dr. Schultz, so I hope you will all understand this is really nothing personal but something which is institutional which has prompted me to take this position today.

I would like to now ask Dr. Simmons this one question. Let me first say I am disappointed again that the administration has not yet made its annual report on progress achieved in meeting the 5-year plan submitted to Congress pursuant to Public Law 91-572. That report was due by law on January 1.

Again the same pattern of tardiness and disregard of statutory authority has been displayed, as was shown in the late submission of the previous two reports.

The original 5-year plan was due June 24, 1971. After considerable prodding on my part, and on the part of Mr. Staggers of the House Interstate and Foreign Commerce Committee, it was finally submitted on October 12, 1971, 2½ months late.

The first progress report, due January 1, 1972, was submitted to Congress on February 7, 1972, again only after written and personal request to the then Secretary of HEW.

The second progress report was due January 1, 1973, and has not yet been submitted to Congress, 4 months later.

I have written a number of letters, first to former Secretary Richardson, then Secretary Weinberger, asking for this report. I finally asked that, as chairman of the subcommittee having the responsibility for implementation of programs authorized by title X, a copy be made available for my background information. I was very grateful that the then Secretary did make this copy available to me. However, there is a need for programs in the community and for individuals and organizations in the public sector to have access to the information contained in the final report as well.

Finally my question: Can you tell me when this report will be submitted to Congress?

Dr. SIMMONS. Mr. Chairman, before answering that I would like to apologize for the tardiness of the testimony and the report.

One thing I hope you will keep in mind is this is 1 of our 6 hearings this week, and we have been up on the Hill about 15 times in the past 3 weeks, all of which has been an unusually excessive load on the Department.

That is not an excuse for the lateness, but I hope you will bear that in mind.

Senator CRANSTON. Again, when will it be submitted?

Dr. SIMMONS. It should be here in the next day or so.

Senator CRANSTON. In the next day or so?

Dr. SIMMONS. Yes.

Senator CRANSTON. We will get in touch with you about a future date when you can answer some questions.

Our next witness is Dr. Alan Sweezy, chairman of the Planned Parenthood Federation of America, also professor of economics at the California Institute of Technology.

STATEMENT OF ALAN SWEETZ, PH. D., CHAIRMAN OF THE PLANNED PARENTHOOD FEDERATION OF AMERICA; PROFESSOR OF ECONOMICS, CALIFORNIA INSTITUTE OF TECHNOLOGY, PASADENA, CALIF., ACCOMPANIED BY FRED JAFFE, DIRECTOR, CENTER FOR FAMILY PLANNING PROGRAM DEVELOPMENT, PLANNED PARENTHOOD, NEW YORK, N.Y.

Dr. SWEETZ. Thank you very much, Senator Cranston. I very much appreciate the opportunity to be here before the subcommittee.

I have submitted a prepared statement, and will not read the text of the statement. I would like to make a few summary comments, and then I will be glad to answer any questions that you may have.

Senator CRANSTON. I appreciate that approach very much. Thank you.

Dr. SWEETZ. It seems to me that this bill is a very excellent one from our point of view, and I would think also from the Government's point of view. First and foremost, it provides a solid basis of financial support for family planning services and population research.

Everybody admits the need for family planning and population research, including the spokesman for the administration. The only question is how should these activities be supported financially, and what kind of administrative setup should accompany that support.

My reason for saying that I think that this is an excellent bill is that it does provide a firm basis for financial support which is greatly superior to the prospect that we would have if the alternative course were taken.

It has been suggested that title X of the Public Health Services Act be allowed to lapse, and that other channels for supporting family planning services be used. It seems to me there are two things wrong with this.

First, that the actuality of the support through these other channels seems to be very questionable. In other words, everything that we know about the record so far and the prospect suggests that it is quite unrealistic to think that family planning programs on the scale that we have had, and that we need in the next few years, can be supported in these other ways.

I would just like to say a little bit more about that. We are told that title XIX and title IV(a) of the Social Security Act will be major channels for financing family planning services. So far they have been minor sources of support, and the prospect seems to be poor that they will improve.

In fact, just to give you one illustration, as far as title IV(a) goes, instead of expanding, it seems that support is likely to contract with the regulations which are proposed to govern the availability of funds under that title.

There is one illustration of this that struck me as so vivid that I would like to take a moment to mention it. As one of the conditions for eligibility, a potential recipient seeking family planning services would have to first apply to the welfare department and have a case

file established in the same way that it would be required if he or she were applying for financial assistance.

A caseworker would have to assess the person's circumstances to determine if family planning services would be an appropriate part of an overall social services plan to assist that individual in maintaining self-support and self-sufficiency.

This is for each individual, drawing up a plan, with all the circumstances of that individual's case in mind—for one thing, of course, the individual could easily become pregnant while this process of drawing up a plan was going on, which is what family planning services are designed to prevent in case the pregnancy is not desired.

It would cost a tremendous amount in terms of administrative personnel required to make the examinations and the determinations of all these thousands, in fact, couple of million plans—well, it would not be that many people qualifying, but there would be many thousands of individuals involved.

As a final disadvantage, this would disrupt the activities of the health and planning agencies to such an extent that they would probably just throw up their hands and not use the provision.

Well, I do not want to take time to go through other restrictive regulations, but there are a number of others that are being proposed, and the prospect we would actually get increased support in view of these regulations seems to be dim indeed.

My second reason for preferring the kind of financing which is envisaged in this bill rather than the methods that the administration is suggesting is that it seems to me that it is a good thing to have the financing concentrated, or largely concentrated, in a uniform program which makes coherent planning possible, and then makes review and evaluation of the progress we have made in achieving these plans possible.

The alternative path seems to me to be that we will have things scattered all over the place, and it is going to be very hard for anybody to have a consistent overall view of what we propose to do or what we are actually accomplishing.

The bill also in addition to providing a firm foundation for financing and the unified and accountable system for carrying out the family planning activities strengthens the administrative structure in several ways which I think are highly desirable.

I will mention one other feature of the bill which we support strongly, and that is in section 1004(a), part 2, where an estimate of the total costs is required, not only an estimate of the total costs but also the amounts which it is expected will be met by the Federal Government, by State and local governments, and from private sources.

It would be difficult to determine these amounts exactly, but I think even a rough indication would be helpful. We feel strongly that the private sources should continue to be involved in the financing of family planning. There are a number of reasons for that which I will not go into but which I think are fairly obvious.

At the present time the difficulty is that with large-scale Federal financing many private sources tend to feel that the responsibility is no longer theirs and that the Federal Government will do the whole thing.

If it were explicitly spelled out that private sources should continue to be active, and a rough indication given of the magnitude of their

contribution. I think we would find it a good deal easier to overcome this disposition to put the whole burden of supporting family planning onto the Government. So that is another reason why I would strongly support the approach, or this particular feature of the approach, in the bill before us.

We also are very much in favor of the provision in section 1006(c) of part 3, calling for provision, either directly or through linkages with other health agencies, of a comprehensive range of child and maternal health services. This is something that we are working toward, and we feel it is desirable that we should continue to move in that direction.

As to section 1008, some modification might perhaps be considered. Our emphasis, of course, is on family planning to prevent unwanted pregnancies. They, however, still do occur, and until we have perfected our program and our means of birth prevention, probably will continue to occur, and where unwanted pregnancies occur, tragic results often follow.

It does seem that in these cases it is wise for us to provide pregnancy testing and counseling, and perhaps the prohibition against support through Government funds should not be made too rigid in order to allow women to determine freely in the case of the unwanted pregnancy if it does occur what the outcome should be.

That is all I have in the way of prepared remarks, Senator Cranston. Senator CRANSTON. Thank you very much. Your testimony has been most helpful to us.

Your full statement, of course, will be included in the record in its entirety at the conclusion of your testimony.

Dr. Sweezy, the administration stated that the proper Federal role in family planning is to reduce financial barriers to health services. Do you agree that financial barriers are the greatest obstacles in the way of the millions of individuals who want family planning services but do not have access to them?

Dr. SWEEZY. Yes, I would say that financial barriers are very serious, and in a way they are the basic barrier because with adequate financial resources it is possible to overcome the other barriers which are chiefly ignorance through an educational and information system, but that takes money.

Senator CRANSTON. Is it your opinion that development of new family planning programs is essential in the areas where there is limited availability of those services?

Dr. SWEEZY. Yes. I think that we have not yet covered the whole field by any means, and that there are areas that are scarcely touched, and that we need to expand our services.

We have come a long way. We have done a great deal, and we of course have to maintain those programs which are now operating. They do not maintain themselves; they have to be continued, but we also need expansion.

Senator CRANSTON. Is it your opinion that not training the estimated 200,000 individuals which the 5-year plan determined would be needed to provide these services, who would not be trained if the administration proposal is accepted, would create a major obstacle to expansion of family planning programs?

Dr. SWEEZY. If they were not trained?

Senator CRANSTON. Yes.

Dr. SWEEZY. Yes. I feel very strongly.

Senator CRANSTON, if I may, I would like to ask Mr. Jaffe to supplement my remarks on some of these points.

Senator CRANSTON. Certainly.

Mr. JAFFE. To return to your first question, Senator Cranston, the barrier of financial inaccessability combines with a barrier which essentially is that many low-income people do not have a normal source of health care, and really what this program has done under Public Law 91-572 is to provide a first line of primary care and comprehensive care for low-income women of childbearing age.

It is a combination of both geographic and financial inaccessibility that I think has thus far prevented many low-income people from practicing modern family planning.

The training question relates exactly to that configuration of lack of health programs, lack of trained personnel, working in these communities, and it becomes extraordinarily difficult to provide these services unless you can train the personnel, put the programs in place, and that is precisely what the project grants have facilitated these last 3 years.

Senator CRANSTON. Thank you very much.

Is it your belief that a great deal needs to be done in the research field to develop a safe and effective method of controlling fertility?

Dr. SWEEZY. We certainly do not yet have a perfect method by any means. There are problems connected with both the pill and the IUD, and we would be a lot further along toward our goal of providing safe and acceptable family planning in this country, even more in the rest of the world, if we could find a method of contraception or methods which did not have these drawbacks.

Dr. Segal has said recently that with the present basic knowledge some essentially minor variations on our present types of contraceptives can be developed, but that he feels it is impossible to go beyond that with our present knowledge of the reproductive process, and that really important further progress will require considerable further basic research.

Senator CRANSTON. In the light of the reduction in the level of funding included in the President's revised budget for fiscal 1973, do you agree with Dr. Simmons' statement that current organized programs are expected to continue growing in fiscal year 1973?

Dr. SWEEZY. I think it will be very difficult for them to continue to grow. Of course, there is the familiar inflation factor which means that a constant dollar amount is decreasing in real terms. It is at least 6 percent a year.

What we buy, of course, is chiefly services, so that the appropriate price index for our activities is not the Consumer Price Index but is the wage and salary index.

In addition to that, we still are not satisfying the current demand in a thoroughly satisfactory way, in that we still have waiting times in many of our clinics which are excessive, so that I cannot see how we can.

Then also the kind of geographical expansion that Fred Jaffe mentioned, I cannot see how with this level of funding we can continue to expand in satisfactory fashion.

Senator CRANSTON. Mr. Jaffe, do you have any comment on that?

Mr. JAFFE. I think that we will begin to see it tapering off. There is a lag between when the project grants are awarded and when the services go into place, and I think we will see a tapering off toward the end of this fiscal year.

It will be impossible to continue the 32 percent rate of growth the program has experienced since 1969, unless the funding also increases. This is true in any program where you not only enroll new patients but have to maintain a sizable current caseload, and it keeps multiplying.

Looking at the administration's testimony, I am sure you have the feeling, Senator, that I had of *deja vu*.

Essentially the position of the HEW on this program has been very consistent since 1966. In 1966 they first proposed to do it publicly under the Comprehensive Health Planning Act, except privately they told us in those days they did not think they could do it.

The progress that has come in this field since 1966 has come under congressional specifications and earmarking. It has not come under the comprehensive arrangements, and for the administration to try to contend that we can have this rate of growth under medicaid or title IV(a) belies what they know of the experience of the last 5 or 6 years.

What is more, Secretary Finch when he appeared before this committee had the candor to put the right word on it. He said: We play a lot of Mickey Mouse with these figures. That is what they are doing today.

It is now 6 months after the social security amendments of 1972 were adopted by the Congress. There are no regulations to implement the mandatory family planning provisions of those amendments. There is no plan in HEW to provide a Federal regulation which says States have to buy family planning services from all providers, and not choose among them which ones they will pay for services and which they will not.

The title IV(a) regulations that were finalized last week, where they had another opportunity to implement what they call the congressional mandate of the social security amendments, interestingly, they do not do for family planning what they did for day care, which is to enlarge the eligibility level for subsidy for potential clients.

We are talking about a program in family planning where perhaps one-fifth of the need are welfare recipients and the balance are people of very low or marginal incomes who really cannot afford to pay \$65 or \$70 a year which is required to practice family planning.

If they had a consistent position in HEW you would have expected that the title IV(a) regulations that came out last week would have reflected the position that says: Make maximum use of title IV(a), therefore applying to the family planning services the same criteria for judgment that they apply for day care. They did not.

It is very difficult from a program end to see how this policy can do anything but sentence the program to a slow death.

I think the position taken by the administration today represents implicit disavowal of the goal that the President asked for in his 1969 population message, and that was articulated in the 5-year plan submitted in 1971.

I do not see how we can get there under this policy.

Dr. SWEETZ. May I add a word, Senator Cranston, to that?

Senator CRANSTON. Yes, please do.

Dr. SWEETZ. I was really rather alarmed to learn on page 11 of Dr. Simmons' statement that they project a shift from the project grant programs by the Federal Government to medicaid programs in which States assume the major role in determining program needs.

I think most of us in the family planning field would look with considerable alarm at a takeover by the States of the responsibility for family planning. We have seen too much of the difficulty that States have in not only putting up their share of the financing, but in mobilizing the real concern for this type of thing.

Senator CRANSTON. Thank you both very much for your very strong and I think sound comments.

Dr. Sweetz, you indicated in your statement that your organization, although doing sizable fund raising, is at sort of a standstill in that respect. Can you explain why that is?

Dr. SWEETZ. Yes. I think there are three factors involved. One I have mentioned already, that some of our substantial donors feel that because the Government has come into the family planning field in a big way they no longer need to do anything. That is certainly one difficulty.

A second difficulty is that we have received considerable support from foundations, and as you know foundations are a restless lot. They will support something for 2 or 3 years, and then they want something new. Whether the new thing is half as important as what they are already doing seems often to be not too great a consideration.

Then I would say that the third factor is that the drop in the birth rate has led people—again I think quite erroneously—to feel that family planning does not need support or does not need support on the scale that it has been receiving before.

I think that is quite wrong. The drop in the birth rate does not indicate a lessened need for family planning at all. It is something which I as an economist and student of population welcome, but I do not think reduces the need for our services.

Senator CRANSTON. What is the real significance of the drop in the birth rate? What does this signify?

Dr. SWEETZ. Of course, in terms of society in general it brings me back to the hearings that your subcommittee held a little more than a year ago on a policy to work for a stable population in the United States.

From that point of view it certainly would be welcome that our birth rate has dropped to the long-range replacement level, and we hope very much that it will stay there.

As far as family planning goes, as I indicated, the first consequence of the drop in the birth rate is to reemphasize our traditional goal, every child a wanted child. Tragedy can still occur at a low birth rate in terms of individual needs.

The second point of course is that controlled fertility is a dynamic process. It is like education of children. It does not stay there once you have reached a certain degree of acceptance. When people say we really have not a family planning job to do anymore, I think a good analogy would be in saying in respect to our educational system because we have now reached all the children in the country and have them in

school at least, education is no longer an important process, no longer an important problem, and we can forget about it.

Both of these things have to be done every day, every week of the year. You have to keep them up.

Finally, it may be even more important to provide family planning services on a low birth rate than on a higher one, because the low birth rate is evidence of the fact that people are trying to keep the family size small, and in trying to keep the family size small they have more of a contraceptive problem than they would have if they had larger family-sized goals.

So I would say as far as we are concerned the low birth rate certainly does not indicate a tapering off or relaxation of our efforts; if anything, it indicates an increase of the effort we should put into family planning.

Senator CRANSTON. What do you think caused the decline in the birth rate?

Dr. SWEETZ. This is a subject which I would love to talk about for the rest of the afternoon, but I know you all have other things to do, so I will not bore you with that.

In a nutshell we do not know what caused the decline in the birth rate. There are a lot of possible contributing factors, and I would say that one of them is the increased knowledge of contraceptives, the increased access to the means of family limitation.

There are many other possibilities, and I will not attempt to go into them any further at this point, except to say there are also some real mysteries in both the previous rise in the birth rate and the so-called baby boom and the drop since 1960.

[The following was subsequently supplied by Dr. Sweetz:]

CAUSES OF DECLINE IN BIRTH RATE

In reply to your question about the causes of the decline of the birth rate in the United States since 1960 I would like to add for the record that there is evidence that improved methods of contraception were a significant factor. In his article "The Modernization of U.S. Contraceptive Practice" in the July 1972 issue of *Family Planning Perspectives*, Charles Westoff says that on the basis of the 1965 and 1970 national fertility surveys, "We have estimated that about half of the nationwide fertility decline between the two periods is due to the improvement in the control of unwanted births." Further along in the same article he adds, "The net consequence of all of these changes in methods has been a significant increase in the use of more effective contraception. undoubtedly the main explanation for the decline in the rate of unwanted fertility between 1965 and 1970 and a major factor in the drop in the nation's birthrate."

Senator CRANSTON. At the hearings which this committee held in October 1971, in the first 5-year-plan projections, we gave a lot of attention to HEW's regulations for priority services and how to define low income for the purposes of obtaining family planning services. Could you give us your views on this whole question of eligibility?

Dr. SWEETZ. Yes. I think there are three ways in which you could define low income from the point of view of the family planning field. The first would be to equate low income with people on welfare. That is a very restrictive definition.

Fred, did you say only one-quarter?

Mr. JAFFE. A fifth.

Dr. SWEETZ. Even less than a quarter of the recipients of family planning aid through organized programs are welfare recipients.

A second way of defining it would be to use the official poverty index, and say that we define low-income people as those whose incomes fall below the official poverty line.

A third way which I think is better than either of the first two is to look at the fertility behavior of various groups in our society and use that as a method of defining what we are going to mean by low income.

Studies that have been made show that in terms of both overall fertility and in terms of unwanted pregnancies, there seems to be a cutoff at something like 200 percent of the official poverty line. Most people above that have access to private physicians. They are not entirely effective in controlling their fertility, but a good deal more effective than people below that cutoff.

Those below it have a considerably higher fertility rate with a much higher unwanted pregnancy rate. It seems to me that in pragmatic terms this is a pretty good definition to use, something of the order of 200 percent of the official poverty line.

Mr. JAFFE. I would like to amplify that briefly.

Senator CRANSTON. Yes.

Mr. JAFFE. The poverty line is somewhere around \$4,200 or \$4,300 for a family of four. It is very interesting in the study that we have just done on the people who do utilize organized family planning programs, almost all of them are below the poverty line; 75 percent as I recall are below $1\frac{1}{2}$ times the poverty line.

The norm in our society is for our people to go get health services from a private physician. People do not come to organized clinics unless they have few alternatives. I think what is happening in planning family systems is that we are beginning to see those groups of the population who do not have effective access to private medical care, and I think it cuts somewhere around twice the poverty level.

Finally, there is an important aspect of this calculation that must be considered, and that is one of the objectives of the family planning program, certainly the one that emerged in the late sixties, is to assist people of marginal income to avoid the dependency that would be associated with involuntary childbearing, because if you are going to define poverty in terms of a relationship between income and family size, if people have an unwanted birth, that can push them into a dependency status.

If you are going to have such a program with such an objective, then it is obligatory that the planning level for that program be rather higher than the dependency level for the poverty level.

That was the argument, the justification, used in the HEW 5-year plan for using $1\frac{1}{2}$ times the poverty index as the planning level, and I think there is justification now in terms of fertility behavior for raising that to somewhere around 175 or 200 percent.

Senator CRANSTON. Thank you very much. Dr. Sweezy, in your testimony, you mentioned the importance of the uniform reporting system. Can you describe that system itself, its value, as you see it, and the problems which it faces?

Dr. SWEEZY. In the first place, if we are to have planning, some idea of how many people are in need of these services, and then how many people we actually reach, we need a reporting system which is uniform to avoid duplication.

We also need a reporting system which will provide us the kind of information for program activities on income level, on geographical locations, and other characteristics.

So I would say it is very important to have a good reporting service, and to have a comprehensive and uniform reporting service.

As to some of the problems connected with developing this kind of reporting system, I would like to have Fred say something, since he has been a lot closer to the technical difficulties involved.

Mr. JAFFE. Senator, the Planned Parenthood Federation pioneered in the development of the uniform reporting system for its own affiliates beginning I believe in 1964, and from that information we began to do evaluations and analyses of who we were serving and what the growth of the program was, and we began to develop some of the information that we subsequently used in assisting the Federal Government to launch the program.

When the Federal program began to take shape in 1968, we participated in the interagency committee with HEW and then OEO, the purpose of which was to try to design a uniform national reporting system that would encompass both federally funded projects and the private sector projects.

The current system is an outgrowth of those deliberations. Our basic purpose was to try to develop the kind of planning information that Dr. Sweezy mentioned, and also because we have a strong feeling that this program could and should be made accountable; that is, we should be able to report back to the Congress, to the people, what the growth was, who was being served, with what kinds of impact.

That system that existed today is unique I think in the health field, and we have therefore a vast amount of information available to us on how people of different kinds respond to this kind of program.

The problems we face are not problems of implementation anywhere near as much as they are problems of essentially administration and politics. There is a very real question as to the future financing of that system. I hope that your legislation will take that into account, because it is one thing to mandate that there be a national reporting system, and then to go through every spring the kind of anxiety that is produced when the National Center for Health Statistics sends out a letter saying: We do not think we should finance this any more; then you go through a whole bunch of meetings because it is not clear where the responsibility for administering and for financing that system lies.

I would hope that the legislation could make that clear, because one of the most important things making this program an accountable program is precisely the existence of that system.

Senator CRANSTON. We are going to have to suspend for a very few minutes.

[Recess.]

Senator CRANSTON. The hearing will please convene.

Dr. Sweezy, the administration, as you know, proposes to fund organized family planning services through the partnership for health authorities and to extend neither title X of the Public Health Service Act, or title V of the Social Security Act, and to terminate the OEO programs.

What do you feel are the implications of this proposal to the programs you deal with through Planned Parenthood?

Dr. SWEETZ. I feel the implications are very ominous. The bulk of the support has come through title X. As I indicated earlier, it is the kind of support which seems to me to be sound in terms of this direction, in terms of the accountability that is involved in it, and in terms of its security.

This other kind of support, if it exists, seems very uncertain. I do not know how our programs can operate effectively under a scattering of dubious sources of support. The whole thing seems to fit in with the kind of change in the conception of the poverty problem and what to do about it.

I think this is particularly serious in the area of family planning where the major purpose is to help people to stay out of the poverty category, to help them to become self-sufficient, to be self-sufficient. Another child, or two or three unwanted children, can easily sink a family into the poverty category, at which time it is too late to provide them with these services.

So it seems to me that this is the wrong emphasis to try to begin to contract the program so that it will only deal with the hardcore poverty program.

Senator CRANSTON. How many patients do you estimate organized programs can serve with the administration's total allocation of \$122 million for organized family planning programs?

Dr. SWEETZ. That figure will give about the same level of support as in fiscal 1972 I think.

Is that right, Fred?

Mr. JAFFE. Yes.

Senator CRANSTON. How many people would that be?

Mr. JAFFE. At the end of fiscal 1972 there were 2.6 million low-income women in all organized programs, not all financed with Federal funds, but that was the total of the organized system.

I would judge that it might grow to 3 million, but it cannot go much higher than 3 million unless there is additional financing.

Dr. SWEETZ. Would there not actually be danger of actual contraction because of the fact that the buying power of that money is less than it was 2 years ago?

Mr. JAFFE. Yes. What is more, the other kind of contraction is that the administration policy which is not yet—it is being administered in 10 different regions in contradictory ways, and you can get all kinds of funny things.

Some projects have been told their grant is going to be cut 30 percent. Others are standing in place. How that is going to impact on the system is very difficult to predict, except that I know it cannot go beyond 3 million.

Senator CRANSTON. The administration has stated it will depend to a greater degree on providing family planning services through private physicians reimbursed by medicaid or by title IV (a) of the Social Security Act. What experience has Planned Parenthood had in utilizing medicaid or title IV (a) authorities?

Dr. SWEETZ. In utilizing those two sections the experience so far is that we receive very limited support from them, with many difficulties in working it out. There is an awful lot of redtape, bureaucratic

overhead connected with them. My impression is that they are extremely inefficient methods of furnishing funds.

Senator CRANSTON. Have there been any problems in receiving full and prompt reimbursements?

Dr. SWEEZY. Yes. You have a lot of bookkeeping, a lot of administrative work, in order to comply with the regulations.

Mr. JAFFE. In some States, Senator, by regulation the medicaid program pays only a proportion of the cost, 60 percent, I think, is the figure that comes to my mind in, I believe, Ohio.

Now, medicaid is essentially geared toward the private physician delivery system, and I suppose the rationale there is that private physicians will continue to subsidize a certain proportion of the medical care of the welfare recipients.

Well, it does not quite work that way in a family planning program. One of the big constraints upon the use of medicaid for family planning programs—I have just seen a survey where only a third of all the family planning provider agencies had any medicaid reimbursement. This is because in many States they say they will provide services by a family physician but not by a health department, or vice versa. Sometimes the pattern may be different in different counties of the State. The administration of that program is very varied.

There is a far greater need for private physician services. It has not been realized yet because it requires some kind of organized effort to generate it, and that organized effort can only come through a project grant financed program.

Senator CRANSTON. Under amendments made to title XIX by H.R. 1, does the Federal Government not provide 90 percent matching?

Mr. JAFFE. Under H.R. 1 they would would pay 90 percent of the cost. As I said earlier, there are regulations, yet there is no definition of what the requirements will be for States to implement. There is no intention, from what we can see, for tough Federal regulations to require that States pay all providers so that you could use that and also account for it.

Whether those regulations will be forthcoming and when, I do not think they are going to impact in any substantial way on programs in fiscal 1974, which it is almost now.

Senator CRANSTON. In view of the delay in issuing regulations you do not feel there is much reason to place much faith in what can be accomplished through medicaid?

Mr. JAFFE. Senator, since they had the opportunity in the IV(a) regulations to show how they would come out with the Federal regulation to maximize the use of IV(a) consistent with what the legislation in H.R. 1 said—and did not take that opportunity, in fact wrote a regulation that will cut in half the few existing IV(a) family programs around the country—I do not see how one can expect that they are going to do anything different on medicaid in title XIX.

Senator CRANSTON. Are there limitations from State to State on the provision of family planning services in terms of eligibility?

Mr. JAFFE. Well, medicaid is for welfare recipients, and in a few States it goes to another group slightly above that.

Really if you had a family planning service financed only through medicaid or title IV, you would be talking about family planning for AFDC recipients and maybe a few others.

What is more, the definitions vary from State to State with the variations in AFDC. I looked at the AFDC standards by State a week ago, and I am trying to remember an example of it, but in Alabama my recollection is that the AFDC standard is something like \$1,100 or \$1,200. I could be wrong. I can supply the exact figure for you, if that will help. This is for a family of four.

In California it is, say, \$3,500. That is the kind of range of difference.

Now, the family planning needs are not that different between low-income people in California and Alabama. They are roughly the same kinds of people, and they are using the current program precisely because it does not have an eligibility level.

If you try to finance this program through XIX or IV (a) alone, you would inevitably be going back to the welfare system and conditioning the whole program in terms of the welfare system.

Senator CRANSTON. Are there limitations from State to State in terms of comprehensiveness of service?

Mr. JAFFE. Yes, basically because there have been so few family planning services financed under either of these authorities.

I would say that there is no consistency yet in what it is that they are buying and specifying. They do not have in the Social Rehabilitation Service, for example, which administers XIX and IV (a), the kind of specific standards for what we mean by family planning service that we have in the National Center for Family Planning Service.

If they want to do something, I would think that is where they are going to start. They have not done that since the 1967 social security amendments. Five years is a long time to wait.

Senator CRANSTON. What about coverage of drugs? Are there limitations from State to State there?

Mr. JAFFE. Yes. Some States will pay for drugs and supplies; other States say no drugs or supplies.

Senator CRANSTON. Do you have a total figure of funding available from nongovernmental sources to support organized family planning services?

Mr. JAFFE. Yes. We start with the figures we know, which are Planned Parenthood contributions, the affiliates, and that is something on the order of \$15 million a year.

To that you would have to add some estimates for hospitals which subsidize part of their program from their own budgets. That would have to be a guestimate.

I would add no more than \$5 million throughout the country, and round it off at perhaps the maximum of \$20 million.

Senator CRANSTON. What is available from State and local governments?

Mr. JAFFE. The survey we did last September showed \$4.3 million total appropriated in about 20 States for health departments, and welfare departments for family planning services.

Senator CRANSTON. How much of that non-Federal source is being matched under the social service regulations but would not be matched under the new proposals?

Mr. JAFFE. That is hard to say, but I would think an enormous proportion would not be matched.

Senator CRANSTON. Would you care to come up with something for the record on that?

Mr. JAFFE. Yes. (See p. 502.)

Senator CRANSTON. What is your estimated cost of providing services to a single individual?

Mr. JAFFE. There have been a number of cost studies in the last year. It would be about \$65 per patient per year for the medical examinations, lab tests, supplies, educational services.

Senator CRANSTON. Does HEW concur in that?

Mr. JAFFE. These studies I am talking about are HEW. I am sorry. I think I misheard your question.

Our cost in planned parenthood is somewhat lower than that, probably because we have a fair amount of volunteers who contribute their time.

Dr. SWEEZY. May I add a local note, Senator Cranston?

Senator CRANSTON. Yes.

Dr. SWEEZY. In Pasadena we are proud of the fact that our per patient cost is just about \$40, including everything; our educational services, outreach, and everything like that, and I just heard today that for the whole Los Angeles regional family planning council area it is, I think, \$47.

Senator CRANSTON. Very good.

Where have new programs been established in terms of accessibility to population groups which previously had limited access to such?

Mr. JAFFE. As recently as 1968, Senator, we could only identify programs in 1,200 counties.

In 1972 that number is up to just under 2,000 counties. These are programs located in the counties.

What Dr. Simmons is talking about in his statement is another kind of measure where they identify a county as having a service available if it is contiguous to one where there is a program which may mean that women drive 50 miles to go to a family planning clinic.

I personally have some grave doubts about the validity of that kind of measure.

What has happened since 1968 is that the program has spread. It always was primarily in large metropolitan areas. That is where the major planned parenthood programs begin. If you look at the map of the United States, you see they have fanned out from those major metropolitan areas to more remote counties, and we have approximately two-thirds of all counties with identified programs at the present time.

Senator CRANSTON. What proportion of these programs now provide for coordination with programs offering comprehensive child and maternal health services?

Mr. JAFFE. I do not know the answer, and I do not know how one would get the answer, because I do not know how you would get information on the availability in most of those counties in comprehensive child care.

Senator CRANSTON. Do you think most do or do not?

Mr. JAFFE. I think that most are in fair coordination to whatever exists by way of maternal and child health systems in those counties. That may be a very important thing to be coordinated because there might not be much by way of child and maternal health care.

Of the 3,000 agencies that provide family planning services, most of them—I do not know the exact figure—the overwhelming majority of them, provide family planning along with other health services.

There are 1,700 or 1,800 local clinics doing prenatal and post partum care. Whether I would call that maternal care system comprehensive in that sense—I personally would not want to do that.

Senator CRANSTON. Many counties are so big geographically or so heavily populated just to say the county has a program is not really indicating how well served the people residing in that county are. In your opinion are there many communities where services are not readily accessible to those who want them?

Mr. JAFFE. Yes. We have tried to evaluate them not in terms of counties but estimates of need in those counties, with the program services as numerator and the estimate of need as denominator.

What we find happening is that the national proportion of need met is somewhere around 50 percent as of 1972; in many counties it is much below that; it is perhaps 20 percent, 25 percent.

In a few counties, particularly in the larger metropolitan areas, it is probably up to 60 or 65 percent. It is that kind of spread and what has been happening. Those differences are narrowing and programs are growing really from 0 percent of need met, moving closer and closer to 100 percent.

Senator CRANSTON. Do you have an estimate of the need nationally for new organized programs and the type of community, rural or urban, needing new organized programs?

Mr. JAFFE. I think if by new you mean new agencies, the primary need for new programs will be in rural areas, because I think that is still underserved most disproportionately.

In the metropolitan areas there is need for expansion to some degree of existing program, but it may also involve new programs. There may be new communities, neighborhoods, where the only way you are going to get a program into that community is to establish it under new auspices. However, that is a process that is different from one city to the next, and it is hard to make a generalization.

Senator CRANSTON. Am I correct in assuming that the nationwide shortage of trained health staff is one of the major factors working against establishing new programs where needed?

Mr. JAFFE. I do not think I would say that personally. I think what has happened in the field shows the ability in this field at any rate to generate fairly rapid expansion and absorb considerable large increases in funding and train the people as you go along.

What I think is important about family planning, and perhaps distinguishes it from other health services, is that the medical component of family planning is a relatively simple one.

There are demonstration projects, in fact, using paraprofessional personnel, trained nurses, midwives, to very good effect, so that we do not have quite the same training problem, and problem of lack of trained manpower, that you would have in more complex medical systems.

However, I think we do need training.

Senator CRANSTON. I want to thank you both very much. You have been very helpful. If you have any thoughts you would like to submit for the record subsequently, we would be delighted to have them.

Dr. SWEETZ. Thank you very much, Senator Cranston.

[The prepared statement of Dr. Sweetz follows:]

TESTIMONY
OF
ALAN SWEETZ
CHAIRMAN, PLANNED PARENTHOOD/WORLD POPULATION
before the
SUBCOMMITTEE ON HUMAN RESOURCES
of the
SENATE LABOR AND PUBLIC WELFARE COMMITTEE
at hearings
on S. 1708
on
Tuesday, May 8, 1973

Mr. Chairman:

I am Alan Sweezy of Pasadena, California. I appear here today before you as the Chairman of the Board of Planned Parenthood/World Population to discuss S.1708, your bill to renew and expand the Family Planning Services and Population Research Act of 1970, which expires June 30, 1973. I would like to take this opportunity to commend you and your committee for developing such a fine bill, and I would like to thank you for moving ahead swiftly in scheduling hearings. I can only hope that we will see as timely action by the rest of the Congress. I believe that the longer renewal is delayed, the more we risk the family planning services projects now in place will be thrown into disarray due to all the uncertainties concerning both funding and administrative functions.

Since the Administration does not propose to renew Title X and has indicated it will seek funding for family planning services only through the general grant authority of Section 314(e), which also expires June 30, 1973, and since the House Committee on Interstate and Foreign Commerce has indicated that it does not intend to renew that particular section of the Public Health Service Act, the people involved in the programs are confused by the Administration's proposals and anxious about their future. Certainly there are no local public or private resources that could serve as a substitute for federal support. Even though our own fund-raising efforts in the past two years have been aided by the National Advertising Council we have barely been able to maintain our level of funding. For example, our national headquarters budget declined slightly from 1971 to 1972, from \$9.91 million to \$9.51 million. The budgets of our more than 190 affiliates which provide services to over 600,000 patients have remained stable or shown only a slight increase during the past two years. I have to point out that the total program is more than five times the size of ours both in terms of funding and in terms of the number of patients served.

We now have in the United States a great reservoir of support for the public subsidy of family planning programs to prevent unwanted pregnancy and childbearing, to lower infant and maternal mortality and morbidity rates, and to foster the bearing of healthy, loved, and wanted infants who will have a good chance to become well-adjusted adults. I think this is attested to by the broad spectrum of support for the Title X programs which is evidenced through the supportive resolutions and statements of diverse organizations and individuals such as the American Home Economics Association, the American Academy for the Advancement of Science, the National Education Association, B'nai B'rith Women, and many others.

Since 1970, we have seen policy statements in favor of a national family planning services program included in the platforms of both the major political parties. We have heard women's rights groups demand that they be provided such services regardless of income and in a manner protective of their health dignity. We have seen public hospitals, some Catholic and other private hospitals and hundreds of public health departments open their doors to those who desire these services. It is the members of Congress, and particularly the members of the U.S. Senate that we must thank for having made this possible. The Family Planning Services and Population Research Act originated here in the Senate Labor and Public Welfare Committee, and once again, it is you, gentlemen, who are responsible for trying to shepherd it through renewal successfully.

I believe that these programs are worthy of your support; they are effective, reasonable in cost, and accountable. Currently, the federal program is providing family planning services to 2.6 million out of the 6.2 million women estimated to be in need in FY 72. It provides good general health care services, including gynecological examinations, pap smears, V.D. screening, breast examinations, urinalysis, and blood pressures. It is probably the largest subsystem for the delivery of health care to low-income women of childbearing age. It is cost-

effective, returning in the second year, nearly \$3.00 to the government for every dollar spent the previous year. The HEW five-year plan provides a model for the orderly expansion of family planning which could be applied to other health care services. The Uniform National Reporting System provides another worthy model and supplies a mass of information suitable for detailed evaluations and guarantees the accountability of the program.

The Administration has proposed that several health programs, which include migrant health activities, family planning, lead-based paint poisoning screening and treatment control programs, be supported through the general project grants authority of Section 314(e) of the Public Health Service Act; I would suggest that this proposal would simply take the decision-making authority with regard to these categorical programs out of the hands of Congress and turn over to the Executive Branch the power to continue to fund any program it unilaterally selects, at what level it chooses. I submit that it is Congress which should determine our overall national health goals and priorities. The Administration has also suggested that we rely on programs such as Title V, Maternal and Child Health, Title IV-A or Title XIX (Medicaid) of the Social Security Act for all further expansion of family planning. In our opinion such expectations are highly unrealistic. HEW is currently phasing out the support of family planning services through OEO and Title V, (MCH). The new Title IV-A Social Services regulations would for all practical purposes limit the provision of family planning services under this program to welfare recipients. In roughly half of the states the Medicaid program serves only welfare recipients and, in the remainder of the states, the eligibility structure for the program tends to exclude those very patients, such as young women who have not borne children, who should be the chief recipients of the services. The Administration's proposals could only do damage to this healthy, functioning program which has grown at an average of 30 percent

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in patient enrollments each year.

For these reasons I commend your bill. We thoroughly agree with the increased authorizations which it provides which are based on the funding suggested by HEW in its five-year plan. We agree that a fundamental reorganization of both services and research programs would facilitate further progress. Reorganization is the only feasible way to bring about the coordination between the service programs funded under the health part of the Department of HEW with those of the welfare part of DHEW.

We deplore the fact that the research program, which holds great promise for the improvement of services, both at home and abroad, has lagged far behind the services program. We think this is due, at least in part, to its current location as one of the three components of the National Institute of Child Health and Human Development. The program may have been limited in its growth due to the need of the Institute to keep in balance the support for the various research activities it administers. The current administrative arrangements created by the 1970 legislation have provided much-needed leadership for the direction of both services and research programs. We feel that placing the services and research programs under the direct line authority of the Assistant Secretary for Family Planning and Population Science would make possible further improvement the management of the programs and provide them with greater visibility and accountability.

I have some detailed comments on other provisions of the bill at this time. The specific mandates with regard to the five-year plan in Section 1001 are particularly useful. The five-year plan mandated by P.L.91-572 helped all of us in the field to understand the size of the task ahead and to determine how

the efforts of voluntary agencies and hospitals could be coordinated with those of governmental agencies. It also made clear the magnitude of financial and manpower resources which would be needed.

In our judgment, the present bill strengthens the plan requirements particularly in Section 1001(a)(2) which calls for the plan to estimate, even crudely if necessary, how much of the fiscal burden will be borne by the federal government, how much can be anticipated from state and local governments, and how much will be needed from private resources. This is important because it makes clear the fact that private contributions are necessary for family planning programs and gives potential contributors an idea of the extent to which the private section is to be relied upon by the federal government in its efforts to finance the entire program. While we think that the amount of support that can be expected from private philanthropy is limited, it will help if the government makes clear that it does not intend to finance the total program.

We also support the requirement in Section 1001(a)(3) that the plan specify the steps taken to maintain and operate the national patient reporting system. This system has been critically important in providing data for planning and evaluation, and in making the program accountable. We would suggest that this section should also specify the steps to be taken to finance the operation of the reporting system, since this question has been raised by the federal agencies within the last year, and the future of the reporting system is in some doubt.

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We believe that the requirements of Sec. 1001 (c) would be very helpful in enabling all of us to understand which aspects of the plan are based on the best professional judgment as to what is necessary and possible, and which aspects have been modified as a result of budgetary considerations.

I would also like to discuss the concept of "low income family" as mentioned in Sec. 1006 (c)(1). In our view, this is one of the most important decisions to be considered by the Congress and the Administration, since it will determine the size, scope and nature of the program. Unwanted and unplanned pregnancy occurs among all socio-economic groups, but it happens more frequently among low-income persons and the consequences of such pregnancies are more acute to them. This basic finding of fertility research justifies a national program which gives priority to serving low-income persons. But this finding applies not only to public assistance recipients, or even to persons below the official poverty index, but also to others in near poverty and with marginal incomes. In the last half of the 1960's women with incomes below twice the poverty level had an average annual fertility rate of 120 births per 1,000 compared to 69 births per 1,000 above this cutoff. It is very interesting that almost all patients of organized programs also came from below this level -- that is, they have very low or marginal incomes.

In planning and developing the program, there is and will be pressure based on budgetary constraints to define "low income" at the lowest possible level. We believe it is very important, therefore, that the legislation contain an explicit definition. We urge that it be expressed in terms of the federal poverty index, which is a national index, rather than the Bureau

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of Labor Statistics' lower living standard budget, which is developed for only a limited number of metropolitan areas. The BLS lower living standard budget falls between 175 percent and 200 percent of the federal poverty index and for all practical purposes, the same effect would be achieved by expressing the standard desired as a multiple of the poverty index. In choosing what multiple, DHEW in its new Title IV-A regulations has given us a clue which may be useful. Under these regulations, the upper limit for any subsidy for day care is 2-1/3 times the AFDC standard in each state. This reflects the Administration's view of who needs certain key devices at public subsidy in order to avoid dependency. We have analyzed the state AFDC standards and found that in 15 states with 32.8 percent of U. S. family planning need, 2-1/3 times the AFDC standard is equal to more than 200 percent of the poverty index. In another 12 states with 15.1 percent of the U.S. family planning need, it is equal to between 175 and 200 percent of poverty. Thus in 12 states with nearly half of all U.S. family planning need, the upper limit for subsidy is greater than 175 percent of the poverty index. These findings would support the use of at least 175 percent of poverty -- and preferably 200 percent -- as the definition of low-income in this legislation.

I would like to commend you for your requirements in Sec.1006(c)(3) and (4) that projects have linkages with maternal and child health services including infertility services and that community participation be assured. These are two concepts which have, heretofore, been included in the guidelines for these programs but deserve to be strengthened and made more visible through specific authorization in the law.

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I would also like to voice our support for the protective provisions of section 1006(c)(6) and (7) which are in line with the guidelines of the Planned Parenthood Medical Standards Advisory Committee with regard to patient safeguards in the conduct of research and in the provision of drugs and other methods regularly available through our affiliates.

We would urge that section 1006(d) be deleted. If programs cannot ask patients what their incomes are, then we will never know if we are serving the groups for whom the program is planned and to whom priority has been assigned. It is entirely possible to ask for income information without imposing a "means test" and indeed many family planning programs now do so, without any apparent difficulty.

We would also like to comment on section 1008. We have always felt that first priority in funding under this act should be reserved to provide family planning services to all who need them. The funds which have been appropriated under this act have not been sufficient to do so. We urge, therefore, that the Committee provide maximum authorizations for the expansion of programs so as to reduce the incidence of unwanted pregnancy and the incidence of abortion. We believe however, that the Committee should give serious consideration to providing some additional funds to support an extensive network of pregnancy testing and counseling which would enable women to freely determine the outcome of an unplanned, unwanted pregnancy. Given our lack of experience with the implementation of the recent Supreme Court ruling on abortion, we are yet uncertain whether public financial support will be needed to provide equal access to abortion procedures to all women regardless of income.

Once again I want to commend you on the bill and its provisions. It is heartening that you have displayed this vigorous interest in the program. Since 1969 the Administration has also evidenced its support for family planning services. We urge that DHEW review and modify its current proposals

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which we believe to be ill-advised. By allowing Title X to expire we end all chances of fulfilling the President's commitment to the provision of family planning services to all those women in this country who want them but cannot afford them. Therefore I urge favorable action on S. 1708 so that we may assure all the people of this country the right to plan their families. I think to turn away from this opportunity to better the health and well-being of millions of American women now when we are so close to accomplishing our goals would be tragic.

Senator CRANSTON. We will now hear from a panel of religious leaders: Bishop James Mase Ault, bishop of the Philadelphia Episcopal area, United Methodist Church, Philadelphia, Pa.; and Dr. James A. Langley, executive secretary, District of Columbia Baptist Convention, Washington, D.C.

I welcome you both. I understand we will be receiving statements from the following religious organizations: The National Council of Jewish Women, the Union of American Hebrew Congregations, the National Council of Churches, the United Presbyterian Church in the United States, the Presbyterian Church in the United States, the United Church of Christ, and the Episcopal Church.

I would appreciate it if you could summarize the main points of your testimony because it is possible we are going to run into some time problems, and we have several witnesses yet to come.

STATEMENT OF BISHOP JAMES MASE AULT, BISHOP OF THE PHILADELPHIA EPISCOPAL AREA, UNITED METHODIST CHURCH, PHILADELPHIA, PA.

Bishop AULT. Thank you, Senator Cranston. I am James Ault, presiding bishop of the Philadelphia area of the United Methodist Church.

Before my election to the episcopacy and appointment to the Philadelphia area, I served as dean of Drew University School of Theology and on the faculty of Union Theological Seminary in New York. Prior to that I was a pastor for 15 years, serving congregations in rural, suburban, and urban settings.

With me today is Dr. James Langley of the District of Columbia Baptist Convention. We had hoped to have with us also a representative of the Union of American Hebrew Congregations. Although he was unable to be here today, the Union does plan to submit a statement to the committee regarding this legislation.

I also understand that representatives of several women's organizations within the Jewish and Christian faiths will be testifying later this week.

We appreciate this opportunity to present our concerns and those of our respective religious organizations for the programs recommended by S. 1708, currently before this committee. The interest of the United Methodist Church in the issues of family planning and population dynamics has become increasingly focused over the last few years, as a long-standing concern for the health and well-being of families has joined with a relatively new recognition of the threats posed to that well-being by unchecked population growth.

Like other organizations and private citizens, the United Methodist Church is attempting to deal seriously with the problems of population growth and distribution in order to ensure individual freedom and dignity for all people.

In 1970 the United Methodist General Conference, sole policymaking body of the denomination, consisting of elected representatives from local churches across the Nation, adopted a statement entitled the population crisis resolution. After examining the dangers posed by unchecked population growth and the possibilities for individual, organizational, and national action in this area, the Conference concluded:

Since the population problem is so acute, imaginative and vigorous action is required on a grand scale. Let us, therefore, act now, that children may not be born to suffer and to experience despair, but rather may be the blessed fruit of love and the hope of a good tomorrow.

This is still the stand of the church, but we recognize that the hopes expressed therein can never be realized so long as individual women and men do not know or cannot practice the means of planning their families.

In a day of increasingly wonderful scientific discoveries and developments in medical research, it is difficult for some of us to realize that the very basic possibility of planning one's family is not yet a reality for many women in this country.

This is caused by a lack of knowledge on the part of individuals, lack of affordable services, and lack of a totally safe and effective contraceptive.

The recent national fertility study, conducted by the Office of Population Research of Princeton University, indicates that of all infants born to married women during the 5-year period from 1966 to 1970, 44 percent were unplanned and fully 15 percent were reported by the parents as having never been wanted.

Unwanted fertility can cause a family to cease to be self-supportive, and can prevent individuals and families from becoming financially independent and economically secure. For others, involuntary child-bearing may be damaging to maternal health, while safe contraception might reduce significantly the incidence of prematurity, infant and maternal deaths, birth defects, and mental retardation.

At the same time that many women suffer in terms of health and family stability from unplanned fertility, others who desperately want to bear children suffer the pain of infertility.

The measures proposed by S. 1708 address both these needs, as it calls not only for the provision of safe family planning services to those who could not otherwise afford them, but also for increasing research in the area of human reproduction, research which can lead to better contraceptives, better understanding of motivations for child-bearing, and better knowledge of the causes and possible remedies for infertility.

We believe that such legislation is essential to the health and well-being of women, children, and families throughout our society.

Of particular concern to United Methodists are the fears of some minority groups that family planning programs may be used by those in power in a coercive manner, leading to the decline or even the extinction of certain minority groups. In light of these feelings, the United Methodist Church in its policy statements calls upon the society to "be aware of the fears of many in poor and minority groups and in developing nations that family planning programs can become coercive and even genocidal in nature; and strive to see that family planning programs respect the dignity of each individual person as well as the cultural diversities of groups."

I believe that S. 1708 speaks clearly to this concern, and I appreciate the fact that sponsors of that bill saw fit to include certain protective clauses. Those sections insuring individual privacy and the voluntary nature of family planning programs, particularly for the poor, and requiring that services be offered when possible in the context of comprehensive child and maternal health care, including infertility serv-

ices, clearly address the anxiety of many and are to be welcomed by those dealing with the provision of services.

Coercion in this most sensitive of areas is surely abominable, and we feel the inclusion of these protective clauses adds significantly to the integrity and value of the proposed legislation.

Fears of minority and poor families have been seized upon by some who charge that, since programs authorized by the Family Planning Services and Population Research Act of 1970 are directed primarily at persons in the poverty or near-poverty levels, they operate unfairly to force poor families to limit the number of children which they have, while allowing more affluent families to have as many children as they desire.

We believe deeply that family-planning programs should never be an excuse for avoiding other measures to alleviate poverty.

The projects funded by this act have served, however, to give to the poor those rights and benefits generally available to the middle and upper class. For the affluent woman who can easily afford the services of a private physician, federally funded programs may not be necessary. A government-funded program must give priority to those who, for economic reasons, are unable to obtain the services of private physicians.

These programs have benefited poor families in another way, by bringing them into a network of health care services not previously utilized by many of them or by their families. In its recent analysis and recommendations of the proposed Federal health budget for 1974, the American Public Health Association noted that "family planning has served not only as a means of fertility control, but also as the only entry point into the health care system for many people. It has also been the catalyst for the development of new types of health manpower for this Nation * * * given the established success of these programs (a decrease in funding), could be a step backward in the Government attempt to control the birthrate and improve the health delivery system."

One other point which I would like to mention for just a moment is the relationship of family planning programs proposed by the legislation before you and the matter of abortion. Indeed, some legislators seem reluctant at this time to give strong support to this and similar legislation for fear that their constituents will believe them to be supporting widespread abortions. This is so despite the explicit prohibition on using funds herein authorized for programs in which abortion is used as a means of family planning.

For some years the United Methodist Church has firmly supported the availability of medically safe, legal abortions. We have seen this, however, not as a means of family planning, but rather as an extreme measure to be undertaken thoughtfully and prayerfully in those situations where the life or health of the pregnant woman or her family is threatened by an unacceptable pregnancy.

It seems to us that, while we may differ among ourselves on the acceptability of abortion, we can all agree that it would be better if abortions were rarely necessary. The best way to insure a decline in the number of abortions performed—legal or illegal—is to make available to all persons desiring them the information and services necessary for medically safe, effective means of contraception, and education in what responsible parenthood means.

In this regard we are particularly aware of the fact that not only must we provide for the extension of family planning services, but we must also provide for continuing research in the areas of human reproduction and contraception. Today many women who can easily afford family planning services are still experiencing unplanned pregnancies due to contraceptive failure.

Of course, we all realize that even the highly effective pill is not totally infallible, and many women cannot use this or other of the more effective means now available because of dangerous medical side effects. For this reason it is essential that the Federal budget include increased funding over the next 3 years for intense research efforts, not only into the perfection of effective and safe contraceptives, but also into the causes and cures for infertility problems.

It is generally acknowledged that reproductive research has never been a major priority for physicians or trained biomedical researchers. Our knowledge of basic reproductive biology is still characterized more by gaps and enigmas than by clearly comprehended patterns. Yet as compared to our understanding of the motivations involved in fertility-related decisions, and the relative effects of social and economic changes on patterns of childbearing, our understanding of reproductive biology is vast.

The U.S. birth rate has fallen sharply in the last year, and is now at replacement level, yet we do not really know why. And therefore we do not know whether it might go up again if circumstances or factors change.

If we are to derive much needed answers and insights in all these areas, and to develop several options of better contraception, we must encourage new research efforts in these areas. The creation of a National Center for Population Science, with adequate funding for basic, applied, and social science research as well as for training personnel to carry out such research, is an essential step in the effort to bring a halt to population growth and to assure the possibility of individual choice in matters of fertility.

I spoke a moment ago about the fears of some minority groups of domestic family planning programs. In a real sense this same fear is present on the international scene, as individuals in third world nations view with concern and suspicion the willingness of the United States to invest foreign aid moneys in family planning programs for their people.

In light of this concern, it may be that the greatest contribution the United States can ultimately make as its part in a mutual worldwide effort will be in the area of research. Our Nation is particularly rich in terms of its research capabilities and resources.

The benefits of research made possible by this legislation in the areas of human reproduction, contraceptive development, and population dynamics can be expected to yield benefits far beyond our own borders in the years to come.

As a United Methodist bishop I have a special interest in this area of possible benefit. Recently the Council of Bishops of the United Methodist Church issued a "Call for Peace and the Self-development of Peoples." In that call we noted among the enemies of peace today the threat of increasing population growth for both developed and the developing nations, and concluded that concerned and adequate efforts

to work together to stop population growth are essential if we are to maintain peace and indeed human life as we know it on this earth.

We recognize the danger of the developed nations simply exporting their own values and goals along with their assistance. I believe that through focusing in our own country on the needs of families and on increased programs of research, we can produce information and materials which can be used well by the people of other nations, according to their own needs and national aims.

There is one final provision of S. 1708 which I would like to comment on just briefly. This is the proposal for an Office of Family Planning and Population Science in the Office of the Secretary of DHEW, to include a National Center for Family Planning and a National Center for Population Science.

The United Methodist Church in 1970, recognizing the crisis nature of unchecked population growth, called for the establishment of a major agency to deal with that crisis. The proposed Office of Family Planning Services and Population Science would fulfill this objective, providing not only greater visibility for this concern within the national Government, but also improving the coordination, effectiveness, and mutual development of the service, research, educational, and training aspects of fertility and population related programs.

In closing let me emphasize that our primary concern is for the quality of life and the assurance of dignity to each individual and family. We are attempting to deal as a church with the problems of population growth not simply because we fear a crowded planet, but because we are convinced that uncontrolled growth rates may lead to a world in which resource depletion, food shortages, overwhelming demands on a Government designed to function best in a smaller setting, increasing restrictions on individual choices, and competition for limited resources may make life with dignity almost impossible for millions of individuals.

We are calling for increased research into reproductive biology and population dynamics and for broader availability of family planning services not in order to demean the value of a single human life, but rather to insure that each individual will be born into a family which is prepared to love and care for that child, and to strengthen the family by making childbearing a matter of responsible choice.

I would like to conclude with an excerpt from the United Methodist statement on responsible parenthood:

We affirm the principle of responsible parenthood. The family constitutes the primary focus of love, acceptance, and nurture, bringing fulfillment to parents and child. Personhood develops as one is loved, responds to love, and in that relationship comes to wholeness as a child of God.

Each couple has the right and the duty prayerfully and responsibly to control conception according to the circumstances of their marriage. They are in our view free to use those means of birth control which meet the approval of the medical profession.

As developing technologies have moved conception and reproduction out of the category of a chance happening into the realm of responsible choice, the decision whether or not to give birth to children must include acceptance of the responsibility to provide for their mental, physical, and spiritual growth, as well as consideration of the possible effect on quality of life for family and society.

It is to insure to every family, poor as well as affluent, the possibility of choosing parenthood responsibly, for the sake of the child, the family, and indeed the world, that we gladly support the proposed

Family Planning Services and Population Research Amendments of 1973.

Senator CRANSTON. Thank you very much for your fine statement, Bishop Ault.

Dr. Langley, did you have a statement also?

**STATEMENT OF DR. JAMES A. LANGLEY, EXECUTIVE SECRETARY,
DISTRICT OF COLUMBIA BAPTIST CONVENTION, WASHINGTON,
D.C.**

Dr. LANGLEY. Yes, Senator Cranston.

I am pleased to testify on behalf of Senate bill 1708. In a broad sense I speak on behalf of nearly 2 million members of the Baptist General Convention of Texas and 12 million members of the Southern Baptist Convention.

The view which I represent grows out of Baptists' understanding of the essential nature of man, in this context; namely, that first, every person is a being of infinite dignity and worth, with the corollary that every child has the right to be wanted, and cared for, for his or her own sake; second, the sex within marriage is meaningful in itself quite apart from the transmission of life or the possibility of transmission of life, offering at least the possibility of creating a kind of exalted relationship between two persons which is possible in no other way; it does not require justification by the possibility of propagation; third, that procreation is one of the highest goals, but only one of the goals of sexual union in marriage, which carries with it awesome responsibilities for the well-being of the offspring.

In 1968 the Baptist General Convention of Texas in annual session approved a statement on family planning, the partial text of which reads as follows:

Every hour world population grows by 5,000 persons. Every day at least 10,000 die of malnutrition. Every week the tide of people rises by more than a million. We must recognize that much help for those in desperate human need is nullified by the continued population increase and that many children being born into the world are unwanted, uncared for, undernourished and underprivileged.

Full family life education must be available to all citizens, particularly to the poor and uneducated. An affirmative public policy regarding birth control information is required in order that the right of free choice in the private life of husband and wife may have a basis in fact rather than being an empty slogan. We see any system, religious or political, that supports a mandatory, * * * imposed ignorance of modern medical advances as dictatorial and inhumane.

Therefore, we support the programs of the Public Health Service and other government and private agencies that offer health and hope to mothers otherwise trapped in a cycle of annual pregnancies. We see that planned parenthood, practiced in Christian conscience, may fulfill rather than violate the will of God.

I will not read the resolution adopted by our denomination, the largest evangelical body in the United States in 1967. It is included in my prepared statement.

Senator CRANSTON. Your entire statement will appear in the record, at the conclusion of your testimony.

Dr. LANGLEY. Thank you.

We agree with the Senator's statement at the outset today that coordination as well as services will suffer from the allocation of responsibility for funding services to the State levels.

The record of accomplishments to date by the Federal Government giving to the States a surrogate role, particularly in such a sensitive and yet critical field, offers little hope for progress in this area.

In our view the availability and use of safe and effective means of birth control would go far toward eliminating the profoundly disturbing questions and problems related to abortion in many instances.

There is no thought or desire to impose by force or Government action our convictions in these matters. At the same time each married couple desiring information concerning family planning ought to be able to obtain it.

We are rightly appalled at the slaughter of human beings in warfare. Why should we not be appalled by millions being condemned to death by malnutrition, starvation, and other causes beyond their control?

Diligent efforts must continue to increase food production and distribution to feed the world's masses, but in many nations these measures cannot hope to keep pace with the galloping population growth. Medical care and education appear to be hopelessly outdistanced. Commendably, our Nation is spending hundreds of millions for medical research to extend life.

It is unthinkable, if and when cures for heart disease, cancer, and other dread maladies are discovered, that we should withhold them from other nations. Is it rational, to say nothing of compassionate, not to exert the most determined effort through research to provide effective means of determining whether a child shall be born with hope for something of the fuller life, and safe means of contraception in order that the mother's life may also be safeguarded?

What we seek is more than mere existence. We seek to make quality of life, not a hollow phrase, but a reality for all. We believe Senate bill 1708 would make a significant contribution to that end and urge its passage.

Senator CRANSTON. Thank you very much. I deeply appreciate the very fine statements of support for a worthwhile program from both of you and from those you represent.

Bishop Ault, you spoke just briefly in closing of your concern for the quality of life. Could you elaborate a bit on how you see that as it relates to this legislation.

Bishop AULT. Yes, Senator.

First of all, we favor family planning not just as a means to stop population growth but as a matter of human right and dignity. We want to stress and lift up the importance of family life, because in the context of the family the psycho-sexual development of the child begins, and in large measure what happens there determines his own self-understanding, appreciation, and how in fact he will relate to other persons and see them as persons also.

It also involves responsibility of choice, freedom of choice. These programs are not imposed upon a family, but the services rendered based upon research are provided the family through a communications network to gain understanding, and then they make a choice of whether or not they would participate in these programs.

Finally, the importance of women being able to plan when to have children we stress; that parenthood is a blessing and not in some instances an unavoidable fact of life. These are some of the things I had in mind when I included that statement.

Senator CRANSTON. Thank you. I would like to pose this question to either or both of you.

The bill contains authorizations for money to be used in the development of educational materials. Do you think it is appropriate for the Government to become involved in developing educational materials for the sensitive area of responsible parenthood?

Dr. LANGLEY. I do indeed. I am conscious of the fact that the whole question of sex education is a very sensitive one; that this is not the direct purpose of this, but rather strictly in the sense of family planning.

But I believe the Government not only has the right but that the responsibility lies with the Government to support the private sector on behalf of the people who otherwise would not have adequate funds for this.

Senator CRANSTON. What do you see as the Government's proper role in regard to the problem of population growth in other countries? Should it be limited to whatever can be done in the field of research to provide technical assistance, or should we also fund service programs in those countries where they want our help in that way?

Bishop AULT. Senator Cranston, I would respond in this fashion. First of all, given the resources we have in this country—by that I mean scientific, technological, and financial resources supporting the research programs, sharing the conclusions of the research with the nations of the world, not imposing but letting them share in similar fashion with this country, a nation might turn to us either unilaterally or multilaterally and ask for our assistance.

I think the population issue is so fundamental to the whole Earth and all the families of the Earth, including the nations, that we should make whatever scientific knowledge we have available to them and help support it if necessary.

Dr. LANGLEY. May I add a word, Senator?

Senator CRANSTON. Yes.

Dr. LANGLEY. The billions our country has spent in foreign aid have often been undercut by the fact that we simply cannot meet the burgeoning needs in the field of a whole range of social services, whereas by comparison a much smaller sum spent in this area at the request of these nations—of course, only at their request in terms of research and funding—will I think bear the highest dividends.

Senator CRANSTON. Thank you very, very much. Your testimony has been most helpful.

Bishop AULT. Thank you for the privilege of being here.

[The prepared statement of Dr. Langley follows:]

Testimony of Dr. James A. Langley, Executive Secretary of the District of Columbia Baptist Convention, before the Subcommittee on Health of the Senate Labor and Public Welfare Committee on Senate Bill 1708.

Mr. Chairman and distinguished members of the Committee, I am grateful for the opportunity to testify for Senate Bill 1708. In a broad sense I speak on behalf of nearly 2 million members of the Baptist General Convention of Texas and 12 million members of the Southern Baptist Convention.

The view which I represent grows out of Baptists' understanding of the essential nature of man, in this context namely that (1) every person is a being of infinite dignity and worth, with the corollary that every child has the right to be wanted, and cared for, for his or her own sake; (2) secondly, that sex within marriage is meaningful in itself quite apart from the transmission of life or the possibility of transmission of life, offering at least the possibility of creating a kind of exalted relationship between two persons which is possible in no other way; it does not require justification by the possibility of propagation; (3) thirdly, that procreation is one of the highest goals, but only one of the goals of sexual union in marriage, which carries with it awesome responsibilities for the well-being of the offspring.

In 1968, the Baptist General Convention of Texas in annual session approved a statement on family planning, the partial text of which reads as follows:

Every hour world population grows by 5,000 persons. Every day at least 10,000 die of malnutrition. Every week the tide of people rises by more than a million. We must recognize that much help for those in desperate human need is nullified by the continued population increase and that many children being born into the world are unwanted, uncared for, undernourished and underprivileged.

. . . Full family life education must be available to all citizens, particularly to the poor and uneducated. An affirmative public policy regarding birth control information is required in order that the right of free choice in the private life of husband and wife may have a basis in fact rather than being an empty slogan. We see any system, religious or political, that supports a mandatory, . . . imposed ignorance of modern medical advances as dictatorial and inhumane.

Therefore, we support the programs of the Public Health Service and other government and private agencies that offer health and hope to mothers otherwise trapped in a cycle of annual pregnancies. We see that planned parenthood, practiced in Christian conscience, may fulfill rather than violate the will of God.

Our denomination, the largest evangelical body in the United States, adopted in 1967 this statement on family planning:

Whereas, God has blessed . . . man with the knowledge and skills of medical science for the benefit of mankind, and

. . . over population and the threat of mass starvation are posing an increasing problem in many parts of the world, and

. . . it is the responsibility of parents to determine the desirable size of families and the spacing of children so as to provide adequately for them as well as for the well-being of the parents, and

Whereas, the biblical concept of marriage teaches sexual companionship of husband and wife, the procreation of children, the worth and dignity of a human life,

Be it therefore resolved that the Southern Baptist Convention commends to those married couples who desire it and who may be benefited by it, the judicious use of medically approved methods of planned parenthood and the dissemination of planned parenthood information.

Various agencies of our denomination have long been involved in sponsoring family planning clinics. All efforts, however, by the private sector are not adequate alone. This is one of those tasks which in our complex world requires strong government leadership in research and services in family planning, and support of the private sector.

Advocacy of serious limitation of the federal role in family planning services, with federal funds being provided to the states ostensibly for the same purposes, is at best, unrealistic, and at worst, an evasion of responsibility,

with incalculable consequences. The record of accomplishments to date by the federal government giving to the states a surrogate role, particularly in such a sensitive yet critical field offers little hope for progress in this area.

There is no thought or desire to impose by force or government action our convictions in these matters. At the same time each married couple desiring information concerning family planning ought to be able to obtain it.

We are rightly appalled at the slaughter of human beings in warfare. Why should we not be appalled by millions being condemned to death by malnutrition, starvation and other causes beyond their control? Diligent efforts must continue to increase food production and distribution to feed the world's masses, but in many nations these measures cannot hope to keep pace with the galloping population growth. Medical care and education appear to be hopelessly outdistanced. Commendably our nation is spending hundreds of millions for medical research to extend life. It is unthinkable, if and when cures for heart disease, cancer and other dread maladies are discovered, that we should withhold them from other nations. Is it rational, to say nothing of compassionate, not to exert the most determined effort through research to provide effective means of determining whether a child shall be born with hope for something of the fuller life, and safe means of contraception in order that the mother's life may also be safeguarded?

What we seek is more than mere existence. We seek to make quality of life, not a hollow phrase, but a reality for all. We believe Senate bill 1708 would make a significant contribution to that end and urge its passage.

Senator CRANSTON. Our next witness is Ms. Joyce Henderson, secretary-treasurer, National Family Planning Forum; executive director of the Los Angeles Regional Family Planning Council.

Ms. Henderson, we are delighted to have you with us.

STATEMENT OF JOYCE HENDERSON, SECRETARY, NATIONAL FAMILY PLANNING FORUM; EXECUTIVE DIRECTOR, LOS ANGELES REGIONAL FAMILY PLANNING COUNCIL

Ms. HENDERSON. Thank you. It is a pleasure to be here.

Senator CRANSTON. What is the National Family Planning Forum?

Ms. HENDERSON. The National Family Planning Forum is a nationwide association of major family planning provider agencies. It was founded in 1970 and has more than 200 member agencies.

I would just like to summarize my written testimony which you have already received.

Senator CRANSTON. Thank you. That would be very helpful. Your entire statement will appear in the record at the conclusion of your testimony.

Ms. HENDERSON. First of all, I would like to say that S. 1708 has been very well received. Family planning programs have begun to experience a tremendous success in providing a service which is broader than just contraception, and we have also been able to break through the cultural barriers which did exist when programs first began.

During the first year of funding in Los Angeles, we had to direct significant dollars to outreach programs, and we served about 7,300 new family planning patients. During the last year, since the program has been so well received by the community at large, we have served approximately 43,000 new patients.

With all the success, we are still facing long waiting times at clinics and service cutbacks. We are proud that patients are coming in earlier in their reproductive cycle and that a majority of new patients have two children or less.

Faced with the shortage of funds in fiscal 1973 and with the extraordinary demand from the communities we serve, many programs attempted to use title XIX and title IV(a) as funding mechanisms. These have not been realistic sources of funds for most projects. In fact, only three States have been able to develop programs that would significantly affect the utilization of dollars for family planning services. These States are California, Louisiana, and Georgia.

We are further hampered by the new HEW regulations regarding utilization of title IV(a) funds. We estimate that 20 percent of the patients we are now serving under title IV(a) are current welfare recipients. The rest of the patients are served under the old HEW definitions of former or potential recipients of assistance, or "medically needy" individuals. Throughout the State of California, about 70 percent of the patients that are served under title IV(a) programs are categorized as either potential or former welfare recipients or as medically needy.

Nationally, the medicaid programs are even narrower and more restrictive in their definitions, which are referenced in my written testimony. The recent study cited in my statement indicates that only about 7 percent of family planning services are provided through the

medicaid system and that this figure could not increase to more than probably 25 percent at best, even with extreme effort on the part of the programs and the administration.

In terms of the family planning patients we are seeing in Los Angeles, approximately 74 percent of our patients are either at or below 125 percent of the poverty guideline as described by OEO.

Given all the problems concerned with family planning services and the tremendous acceptance we have had from our programs to date, we feel that the growth of family planning—and even maintenance of services at the existing level—cannot be accomplished without the passage of S. 1708.

Senator CRANSTON. Thank you very, very much.

Could you tell us a little bit about the Family Planning Forum?

Ms. HENDERSON. The National Family Planning Forum was formed a few years ago, and the main purpose was to bring together the major providers of family planning services so they could exchange information, have a formal network of ideas and information gathering, and develop approaches to solving the problems of family planning programs.

At the last annual meeting, which was just held a week ago, we noted our membership of over 200 individual agencies which provide family planning services.

Senator CRANSTON. The members are different agencies?

Ms. HENDERSON. Yes; individual agencies.

Senator CRANSTON. When was this started?

Ms. HENDERSON. It was incorporated in 1972; however, it first began formulating in the fall of 1970.

Senator CRANSTON. Can you tell us a little about the Los Angeles Regional Family Planning Council, of which you are the executive director?

Ms. HENDERSON. Yes. The Los Angeles Regional Family Planning Council was the first coordinated family effort for a large metropolitan area. It was funded by OEO in 1968. We now fund 20 organizations which provide the actual medical services, and our administrative responsibility includes planning, coordinating, and evaluating the delivery of services in Los Angeles County and also providing funds for the continuation of family planning medical services.

Senator CRANSTON. You do not render the services?

Ms. HENDERSON. No. The Council does not. Our delegate agencies provide the actual services.

Senator CRANSTON. How many individuals are served through your activities?

Ms. HENDERSON. Over the past 15 months, we saw approximately 70,000 family planning patients. Our agencies, in addition to receiving funds through the Federal mechanism, have outside funding in some instances, and we estimate that probably well over 100,00 individuals are served throughout the area.

Senator CRANSTON. What kind of Federal funding do you have?

Ms. HENDERSON. Funding from HEW through title X and also through the California State Department of Public Health, title IV (a) program.

Senator CRANSTON. How much do you get under title X?

Ms. HENDERSON. The title X allocation is \$2.8 million, and I guess your next question will be IV(a), and that is a contract maximum of \$1.24 million.

Senator CRANSTON. You did anticipate my question.

How many patients are you serving under IV(a)?

Ms. HENDERSON. We initiated the program in May 1972. Since that time 20,000 patients have been served. We are only now beginning to achieve full participation because of the time required to develop the system and start-up costs.

Senator CRANSTON. How many of those are welfare recipients, do you know?

Ms. HENDERSON. We estimate that about 20 percent of those patients are welfare recipients.

Senator CRANSTON. What percentage would you estimate are served under the old HEW social services regulations definitions of "former" and "potential" recipients?

Ms. HENDERSON. The rest of them; the 80 percent are under the former or potential or medically needy categories, with the heaviest percentage of that being the potential recipient category.

Senator CRANSTON. The HEW regulations recently issued on social services programs specify that family planning services must be offered and provided promptly to all eligible individuals voluntarily requesting them. However, determination of eligibility is left to the State agency with the requirement that such determination be reviewed every 6 months after the original case-by-case determination required by the new regulations.

What do you think the implications are of those regulations on the availability of family planning services supported by Federal funds to childless couples, to single adults, and to minors?

Ms. HENDERSON. They have a big problem ahead of them. So do we as providers.

The new regulations would cause tremendous cutbacks, if not totally excluding services for those individuals. The whole screening/certification/eligibility process which we would have to implement would be staggering.

Although we would be able to eventually handle part of the increased administrative screening and redetermination processes, we would not be able to provide enough patient services to pick up what we would be forced to drop.

In California we have a nearly ideal situation where a mechanism was established and the State legislature was very supportive, but even with the sophistication of the agencies there, it took approximately 18 months to set up a mechanism for recouping funds through title IV(a). I doubt that this could easily be transferred to many other States throughout the country.

Senator CRANSTON. What do you estimate the impact of the new regulations will be on the number of individuals who will receive services in Los Angeles and throughout California?

Ms. HENDERSON. Since approximately 35 percent of our existing caseload is funded by title IV(a) funds, I would say we would increase the HEW part of the program an additional 20 percent, and if the HEW program was no longer at its existing level, I would imagine that up to 50 percent of our services could disappear. These are my initial impressions; we will have to wait.

Senator CRANSTON. What administrative difficulties do you foresee in conforming with the requirements of these regulations?

Ms. HENDERSON. One of the major difficulties would be the individual States' definition of who is eligible, working out that mechanism as it applies specifically to our State and, in turn, specifically to the county in which we reside.

After that type of criterion has been established, we would experience additional difficulties in trying to implement the new procedures that would be set up to comply with eligibility. As I said earlier, when it took about 18 months to set up the program under fairly flexible definitions and eligibility criteria, I would say we would be back at the beginning in terms of starting the process over again and getting the major involvement of the welfare community.

Senator CRANSTON. Do you have any additional comments on the effect of these regulations on the ability of organized programs as well as private physicians to provide services under the authorities of title IV(a)?

Ms. HENDERSON. Organized programs would not benefit from the new regulations of title IV(a) at all. The current recipient could probably be covered under title XIX, and our participation in IV(a) could be very limited.

In terms of private physicians, even under the current, more flexible arrangement, we have not had significant participation. The work that we would have to do in familiarizing them with regulations and provision of services under the new arrangement would be staggering, and I do not think they would participate at a significant level. We have not noticed that they have participated even in the title IV(a) program.

Senator CRANSTON. Do you know how many States provide family planning services under title IV(a)?

Ms. HENDERSON. On a large scale, only three States: California, Georgia, and Louisiana. In addition to that, there are just a few other States in which a couple of counties have mobilized to provide services, but there are only three well-organized statewide programs.

Senator CRANSTON. Do you know approximately how many individuals are reached by these programs in each State?

Ms. HENDERSON. We in California are seeing under that particular funding mechanism about 20 percent, at the most, of all services. In Georgia the figure is about 33 percent, and in Louisiana about 62 percent.

Senator CRANSTON. What proportion does that number represent in these States of the estimated number of individuals desiring services from low-income families?

Ms. HENDERSON. Through the title IV(a) mechanism or just in general? Of the total need in Louisiana about 75 percent, compared with 16 percent in Georgia.

Senator CRANSTON. What proportion of the national need is then covered in those three States?

Ms. HENDERSON. Although we have about the largest population, I do not think we always had the biggest need. It is about 14 percent of the national need.

Senator CRANSTON. Do you have an estimate of the number of individuals who may lose eligibility for these services under the new regulations?

Ms. HENDERSON. I could be specific as to Los Angeles in terms of losing eligibility, and that figure would be a minimum continuing caseload of about 6,000 (based on the current title IV (a) caseload of 20,000 patients) that we have seen so far in the program.

Senator CRANSTON. Why did you not mention medicaid as a source of funding through your program?

Ms. HENDERSON. Medicaid has not been a realistic source of funding for us for a few reasons. One is that the reimbursement mechanism has been very difficult to work with.

The rigid restrictions they have for who is eligible, the bureaucratic kind of form processing, submission of bills, et cetera, has been very difficult.

Their fee schedule has not been sufficiently high to recoup the cost of providing the service.

We have an additional problem in that the patients are only entitled to two medical visits per month on the medicaid program in Los Angeles, and patients are very reluctant to use their medicaid visits for family planning service. They are much more likely to use them for a crisis oriented service.

In addition to that, we have not had sufficient numbers of family planning clinics actually licensed to provide services under the guidelines of California codes.

Senator CRANSTON. Could the medicaid program in California pick up the cost of services for the patients you will have to stop serving under the new title IV (a) regulations?

Ms. HENDERSON. Definitely not.

Senator CRANSTON. Could you tell us something about the medicaid program nationally? For instance, can medicaid pay for family services provided to non-AFDC related women?

Ms. HENDERSON. No, they cannot. Family planning services are provided to existing medicaid welfare recipients and members of their families. They are not geared to the near-destitute person.

Senator CRANSTON. To every question I have asked you about medicaid you say "No."

Ms. HENDERSON. That is realistic.

Senator CRANSTON. Let me try one more. Can medicaid pay for family planning services to the working poor woman who has not yet had a child?

Ms. HENDERSON. No.

Senator CRANSTON. In light of this, do you think either medicaid or title IV (a) has the potential for providing sufficient funding for the expansion of family planning services to the still unserved portion of the originally projected 6.6 million individuals wanting services but unable to afford them?

Ms. HENDERSON. Medicaid and title IV (a) could not even at this point continue the services that we are currently providing with no expansion. If we had to resort to medicaid and title IV funds, a good minimum 50 percent of the patients would have to seek services elsewhere, and I have no idea, especially in L.A., where we are the only provider for low-income women, where they would go for those services.

Senator CRANSTON. In view of your answer to this question, what are your comments on the administration's proposal that all further ex-

pansion of family planning services be accomplished under these two programs?

MS. HENDERSON. I am not sure why the administration would make that type of recommendation. It reflects a lack of information on the existing situation in relation to title IV (a) and medicaid. It must be noted that title IV (a) funds have been available for sometime, and there has still been no significant commitment by the majority of States to even begin developing this network. Reasonable participation, which we know is still limited in covering services, is still very, very far in the future. In addition, reports have shown that medicaid can possibly pick up no more than—at the most—an additional 18 percent of the patients that they are not currently covering, which has nothing to do with our existing caseload. That proposal is unrealistic.

Senator CRANSTON. I have to agree with you. [Laughter.]

You mentioned a while back that 70 percent of those served in Los Angeles by Council programs fall within an income level which is 125 percent of the Federal poverty level, that being about \$5,300.

If low income were defined as in S.1708—at the Bureau of Labor statistics lower living standard budget currently \$7,214 for a family of four. What percentage of those you are serving would be “low income”?

MS. HENDERSON. Almost all the patients we would see; well over 90 percent in the Los Angeles program.

Senator CRANSTON. I think I will perhaps submit some additional questions for the record, and I want to thank you very, very much for coming all the way to Washington to testify. You have been extraordinarily well informed and straight forward and responsive in your answers, and I thank you for the very concise nature of your testimony.

MS. HENDERSON. Thank you.

[The prepared statement of Ms. Henderson and additional questions by Senator Cranston follow:]

TESTIMONY OF
JOYCE HENDERSON
SECRETARY, FAMILY PLANNING FORUM
and
EXECUTIVE DIRECTOR, LOS ANGELES REGIONAL FAMILY PLANNING COUNCIL
before
the
SUBCOMMITTEE ON HUMAN RESOURCES
of the
SENATE LABOR AND PUBLIC WELFARE COMMITTEE
at hearings on S. 1708
on
Tuesday, May 8, 1973

Mr. Chairman:

My name is Joyce Henderson of Los Angeles, California. I appear here today as the Secretary of the Family Planning Forum and as the Executive Director of the Los Angeles Regional Family Planning Council. Let me describe briefly for you each of these two organizations. The Family Planning Forum is a national association of major family planning provider agencies founded in 1972. Recently its first annual meeting was held in Washington, D.C. on April 29 through May 2. More than 200 agencies were represented at this meeting. Among those agencies represented were private voluntary organizations, such as the Urban League, Community Action Agencies, and Planned Parenthood; representatives of State, county and municipal health departments; and nonprofit private corporations, such as the Los Angeles Regional Family Planning Council and the Maternal Health Services of Northeastern Pennsylvania, Inc. The major goals of this organization include the establishment of a vehicle by which agencies may share and exchange information concerning the improvement of services, the administration of programs, and the development of plans for the future expansion of family planning services programs.

The Los Angeles Regional Family Planning Council is a private, nonprofit agency which administers and coordinates all of the federally funded programs for the provision of family planning services in the City and County of Los Angeles. In the past four years Los Angeles Regional Family Planning Council funds have been used to serve a cumulative total of 92,716 new patients. We were funded initially by OEO and in the first year we served 7,341. This figure seems low because during this time we were developing outreach activities and funds were being directed to non-medical service agencies. Last program year 42,659 new patients were served. Seventy-four per cent have an income at or below 125% of the OEO poverty guideline.

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The LARFPC Five-Year Plan has stated a goal of making services available to approximately 205,000 medically indigent women of reproductive age by 1976 and enrolling 85% of these women in a family planning program. We are currently on target in reaching this goal.

I have been the Executive Director of LARFPC for about 2 years. During this time I have become quite familiar with the various sources of funding for family planning. I want to state that without Title X, family planning services programs in California would still be very small and limited in terms of staff and available services; in fact, the Title X, Public Health Service Act program, known as the Family Planning Services and Population Research Act of 1970, was passed by the Congress in order to supplement the already existing sources of federal assistance for the provision of family planning services to low-income families and individuals. At the time it was passed, total federal expenditures for family planning in the United States were less than \$45 million and there were no plans to expand and increase the two major programs -- either at OEO or under the Maternal and Child Health Services of HEW. Indeed, it was determined that neither the OEO nor the MCH program had the potential for development of services projects of sufficient size and scope to deliver services to the millions of women who wanted and needed them.

Therefore, we became very encouraged about the possibility of establishing new programs and expanding services when Congress passed Title X in 1970, authorizing \$30 million in new funds for family planning project grants in the first year, \$60 million in FY 72 and \$90 million in FY 1973. In addition, \$45 million was authorized for formula grants to the states for services during this same three-year period. These additional funds enabled public and private agencies during

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FY 71 and FY 72 to increase significantly the quantity and quality of family planning services. Certainly we have made significant progress in California but we still have not developed a comprehensive, statewide program to deliver services to all those in need of them. Our programs in Los Angeles and in the state seem to be progressing along the same lines as the national program; currently we are serving about 50 percent of the need.

Nationally only about half of the 6.6 million women in need of family planning services are being served. If the family planning program under Title X could have sustained the rate of growth experienced prior to FY 1973, estimated at an average annual rate of 30 per cent, it would have been possible for the nation to meet the goal established by the President in 1969 when he stated, "I believe...that we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them."

But in order to meet this goal, the nation would have to greatly increase its support for family planning services in this fiscal year and in FY 1974. The Administration's second budget for FY 73 recognizes this by projecting a nearly \$20 million increase under Medicaid and projects a further \$18 million increase under Medicaid for FY 74. It also anticipates a smaller increase for both years in funding under Title IV-A of the Social Security Act.

Faced with a shortage of project grant funds in FY 73 and with an extraordinary demand for services among the population, a number of member agencies in the Family Planning Forum and other smaller family planning providers have sought to supplement their project grant funds by securing payments under the state-administered Title IV-A social services programs. However, statewide family planning programs have been developed in only 3 states -- California, Louisiana and Georgia. This was made possible in all 3 instances, only because the state legislatures appropriated

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specific matching funds for the provision of family planning under the Title IV-A program. We are fortunate in that the ensuing efforts to establish relationships between the local welfare departments, the State Health Department, and local family planning services provider agencies can be described as successful in California. The terms of the state's legislation required that contracts be negotiated with every county welfare department that wished to use the State matching funds to implement services under Title IV-A. A contract was negotiated between the Los Angeles County Department of Public Social Services and the State Department of Public Health and in turn the State Department of Public Health contracted with LARFPC to render services. Now LARFPC includes \$1.24 million in its budget through the Title IV-A program. This same kind of arrangement was negotiated in 55 out of the 58 counties in the state of California. This intricate arrangement took about 18 months to be completed. The legislation passed the State legislature in August of 1971; LARFPC did not receive its first Title IV-A payment until December of 1972. I might add that most programs around the country do not have the staff resources and management competence that we do in LARFPC nor do they have the responsive state legislature and state agencies which made the development of the program possible. They would require considerable technical assistance over an extended period of time to develop similar programs and, in the meantime, would still be forced to rely on Title X funds.

To date, LARFPC has served in excess of 22,000 patients under the Title IV-A contract. We estimate that 20 percent of these patients are current welfare recipients. The rest of the patients are served under the old HEW definitions of past or former and potential recipients of assistance. This arrangement has worked beautifully in the past, and has given us a channel by which we might continue to expand services even though the project grant funds were frozen. However, with the promulgation of the new HEW regulations and the new definitions of "former" and "potential" recipients of assistance, we estimate that we will have to terminate services to over 50 percent of the patients we have been serving under Title IV-A. Unless Title X project grants

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are renewed and funding expanded, we do not at present know how we can even hope to find other funding to pick up the costs for services to these patients. If a program such as ours, is forced to cut back substantially in its use of Title IV-A funds, due to the new regulations, it is difficult to put any great faith in the Administration's projections for budget increases under this program.

We cannot expect to use Medicaid to make up the loss of revenue under Title IV-A. Our Medicaid program, which is one of the more generous ones in the country, is even narrower in its coverage.

This is true nationally; Medicaid is administered under a patchwork of crazy quilt laws which bar the provision of family planning services to any but the AFDC mother or low-income mothers who are the heads of their families. The low-income woman who has not yet had a child is not eligible for health services under Medicaid. It is not until the woman becomes pregnant, has a child, and subsequently becomes dependent on the state that she and other members of her family become eligible for Medicaid. In all states, intact families in the working poor category are not covered at all. In fact, less than 50 percent of the States even cover intact families with unemployed fathers, and this coverage is limited strictly to the period of unemployment. A recent study conducted by Macro Systems Inc. for the Office of the Assistant Secretary for Planning and Evaluation of HEW examined the feasibility of supporting preventive health services, such as family planning, under the Medicaid program. The study concludes, in its executive summary that "...the ambulatory care centers collectively are now deriving no more than roughly 10 percent, and probably nearer 5 percent, of their total income from third-party collections. Unless the basic program concepts of the centers are changed radically, ... the centers collectively probably cannot expect to derive more than about 20 to 25 percent of their income from this source. Even that level will require a considerable effort to attain."

A survey conducted by the National Family Planning Forum last December came to a similar conclusion. It was found that only slightly more than a fourth of

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family planning providers were receiving Medicaid reimbursements and that only 7 percent of their patients were enrolled in Medicaid. The California State Health Department has arrived separately at the same estimate. The Forum survey also demonstrated that the rates of reimbursements were generally far below the cost of providing services. Mr. Chairman, I would like to submit this study for the record along with my testimony.

All these difficulties and exclusions related to the Medicaid program would affect our program in California dramatically, were we to have to depend solely on Title XIX and Title IV-A. For example, since 27 percent of our patients -- and 30 percent of the national caseload -- have not had a prior pregnancy, services could not be provided to them through either a Medicaid or Title IV-A program. This would be a ludicrous and tragic situation at best.

It has also been suggested by HEW that provider agencies look to the State governments for funding to pick up the costs for patients who cannot be served under either Title IV-A or Medicaid. However, less than \$4.5 million was specifically appropriated for family planning services programs by state legislatures in FY 72, and \$1.5 million of this total was appropriated in California, Georgia, and Louisiana. More than half of the state legislatures have never even discussed the need for specific funding. Nor do I believe we will see overnight action by state legislatures should the Family Planning Services and Population Research Act be allowed to expire. As we all know state governments are strapped for funds. The larger more populous states have come close to bankruptcy. The delivery of preventive health services of any kind are not high on their list of priorities. The experience with revenue-sharing and the ways in which these funds have been spent illustrates my point.

The same is true of local governments. Town and City Councils have been concerned with expenditures for fire prevention and public safety. Their revenue-sharing funds have been spent accordingly. Again, Town and City Councils, especially

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in the larger metropolitan areas have not spent their funds on the expansion of preventive health services of any kind. I believe right here in the nation's capital hospitals have been discussing the discontinuance of acceptance of charity cases due to rising costs while the city government has committed the bulk of its revenue-sharing funds to public safety and the building of a new jail. So I do not believe we can look to either state or local governments for fiscal relief and for expansion of services.

Therefore, it is to the Congress that we must look for the continuation and expansion of our programs. The early development of the program was due to the availability of funds under OEO and Title V, MCH, which the Family Planning Services and Population Research Act was intended to supplement; however, the Administration is phasing out support to family planning services under both these authorities and Title X has become the sole source of project grant funds. We are very aware that Title X is our only realistic hope for the provision of services to the more than two-thirds of our low-income population which remains unserved. Without such services, we will lose the valuable ground we have already gained with regard to improving the health care of low-income women. The Los Angeles Regional Family Planning Council provided services to approximately 70,000 women during the last 15 months. It has expanded to nearly 20 agencies including 9 hospitals, 2 public health department systems and 8 independent agencies, such as the Indian Free Clinic, the Watts Extended Health Inc. -- a private physician program, and Planned Parenthood. However, in spite of the tremendous program growth and an obvious desire for this service by the people of the county, we still have an estimated 150,000 women between the ages of 15 and 45 who need services.

What does the termination of family planning services mean to low-income women in Los Angeles, in California, and in the nation? Without these services they will continue to face poverty and unplanned pregnancies, many of which will result in

either abortion or the bearing of unwanted children. It means that just at the time when we have begun to lower our disgraceful infant mortality rates through the provision of improved prenatal care and family planning services, we will discontinue these services.

The closing down of family planning services clinics will also mean the discontinuance of a number of other related preventive health services to low-income women who normally only receive crisis-oriented medical care. For example, we test most of our patients for cervical cancer, V.D., sickle cell anemia, diabetes, and anemia. As a result, in looking at a few of our programs, we have found that as many as 5 percent of the patients have had to be referred for special medical care related to their abnormal pap smears. With regard to V.D. we have had as high as 7 percent positive tests for gonorrhea in our patients; additionally, we have discovered that about 2 percent of our patients have received medical treatment related to anemia. We provide medical treatment related to both V.D. and anemia in our clinics because, to us, family planning programs provide a health service which is broader than just contraception.

One of our most hopeful statistics has been the drop in the age of our patients and the number of children they have already had before entering the program. In 1969, our family planning patients had an average of 3 children. Now a majority of our patients have only two prior pregnancies or less. As I mentioned before, a large proportion of our patients have not yet had a child and are therefore better able to continue or finish their education, become more employable, and have the opportunity to establish themselves sufficiently to contribute to the family income for some time before having a first child.

We are proud of what we have accomplished, thus far, in the state of California, in Los Angeles, and indeed in the nation with the assistance provided to us under Title X. What's more, nationally we have made a lot of progress toward the provision

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of comprehensive family planning services to all those in need of them. However, our momentum has been halted and cannot be regained without the continuation and expansion of the special project grants under Title X. None of the other sources of funds which have been mentioned by the Administration represent realistic alternatives to the renewal of this legislation. Therefore, I respectfully urge that you act favorably on S. 1708 to extend Title X of the Public Health Service Act through FY 76.

[Additional questions submitted for the record by Senator Cranston and the responses thereto by Ms. Henderson, follow:]

Q. 1. The Administration, as you know, proposes to fund organized family planning services through the partnership for health authorities; to not extend title V of the Social Security Act; and to terminate OEO. What are the implications of this proposal to the programs you deal with?

A. 1. None of the Los Angeles programs are currently utilizing OEO funds. However, we do have two projects which are supported through Title V of the Social Security Act. We have not received any funds through the partnership for health authorities to date nor have we seen any demonstrated enthusiasm from this program to contribute to our family planning services programs. We have had quite a good working relationship with the administrators of the Title X program and cannot understand why the Administration wants to tinker with these programs when they are so successful. If Title V special projects are allowed to expire, we could not pick up the difference in funding for the Title V patients under either Medicaid or Title IV-A, given the present eligibility requirements of these two programs. Title V projects could serve the "working poor" category and also recognized "geographic eligibility." The Title IV-A and Medicaid programs require that certain welfare requirements be met by patients—so called welfare characteristics—which all our patients do not have. Therefore, we would have to look to Title X project grants to pick up the non-welfare patient costs if Title V is allowed to expire. Since the Administration has also asked that Title X be allowed to expire and since the Administration has asked for no new increase in funds for this program, I do not know how we will cover all the Title V patient costs at this time. It is likely that we will have to discontinue services to some patients and we certainly will have to turn away new patients who do not fit eligibility requirements for Medicaid and Title IV-A.

Q. 2. How many patients do you estimate organized programs in Los Angeles can serve with the Administration's proposed total allocation of \$122 million for organized programs? Will this be a reduction?

A. 2. A successful family planning services program reaches a point where the patient load is proportionately increasing at almost geometrical rates. One person is pleased with the services provided, tells a neighbor, and the next day half the neighborhood comes to the clinic. Therefore, we find that our patient costs are always running ahead of our approved grants because patient demand is always increasing. The proposed spending level of \$122 million, which essentially is no increase over the 1972 level means that we cannot meet the increased costs due to inflation and other factors. This means that we cannot continue to serve new patients. Therefore, we would have to reduce clinic hours and services in order to stay within the amount first budgeted in 1972. You only have to turn away patients a few times to lose all the momentum you have gained from having a successful program. This does not seem logical nor reasonable to me.

Q. 3. Have there been any problems in receiving full and prompt reimbursements for services provided under Medicaid and title IV-A authorities? Is there a great deal of paperwork involved in applying for reimbursement?

A. 3. We have been running a minimum of two months behind in reimbursement for Title IV-A, Medicaid, because it is not automated and, therefore, has more paperwork, has a still longer time lag between the expenditure of funds and the reimbursement by the State. Hence, without additional funds through the project grant programs under Title X to carry us over the reimbursement time lag, we and other agencies could not afford participation in Medicaid or Title IV-A.

Q. 4. What is the total amount of funding available in Los Angeles from non-governmental sources to support organized family planning services?

A. 4. We are not able to give you an exact dollar figure—private funds are not extremely significant given the magnitude of the federal investment ($\frac{2}{3}$ - $\frac{3}{4}$) of our budget of our total financing:

Three agencies do their own fund-raising.

Four agencies have research grants.

Two agencies have small foundation grants.

Q. 5. Do you have an estimate of the amount of funding available from the local and state governments?

A. 5. We have approximately \$1 million in local and state funds. However, a good percentage of this amount is made up of state funds appropriated to meet the matching requirement for participation in federal programs.

Q. 6. What is the estimated cost of providing services to an individual?

A. 6. Our average cost is \$47 per patient per year throughout the LARFPC system.

Q. 7. Where have new programs been established in terms of accessibility to population groups which previously had limited access to services?

A. 7. Our latest expansions include East Los Angeles, a low-income area with a high birth rate, infant mortality rate and primarily a Spanish surnamed population. We have also recently expanded services into the American Indian community.

Q. 8. What proportion of these programs provide for coordination with programs offering comprehensive child and maternal health services?

A. 8. We require coordination as much as possible in all our programs. We believe that it is very important for those women who come to our services and are already pregnant to receive the best possible prenatal care. We find that we receive many referrals in turn from the agencies dealing with postnatal care of women. We try to do everything possible to guarantee the emergence of a healthy infant and mother.

Q. 9. Are there still many areas where services are not easily available to those who want them?

A. 9. There are at least 8 geographical areas (health districts) in which services are limited; some of these are populated primarily by low-income minority families and individuals—some have a primarily white, low-income population. All need expanded services which cannot be accomplished without increased funding.

Q. 10. Do you have an estimate of the need in Los Angeles County for new organized programs and the type of community needing them?

A. 10. We believe that at least 8 out of the 25 planning areas (health districts) need significant improvement. We need to expand our services to include family planning services as part of the other health services being delivered in these areas already. This would require increased funds which are not now available.

Q. 11. I would assume a factor limiting the establishment of new programs in areas where the availability of family planning services is limited is the nationwide shortage of trained health staff.

A. 11. This is not entirely true of the Los Angeles area since California attracts such large numbers of skilled health personnel. However, nationally, in areas such as Appalachia for instance, it is a little more difficult to find trained personnel and training is very important in this context. Since the training needed has been funded primarily through the Family Planning Services and Population Research Act, it is important that such funding be continued.

Q. 12. Do you have an estimate of the number of organized programs which provide training and the numbers and types of individuals trained?

A. 12. See Attachment, Page 110.

Q. 13. What will be the effect of the Administration's proposal to terminate the training authorities of title X on the ability of these programs to provide training?

A. 13. If the training authorities of Title X are discontinued, the effects on the program would be severe. Since the areas where expansion of family planning services is both desirable and necessary are generally short on trained manpower, it would be very difficult to start up programs without training efforts. As mentioned, rural areas particularly need the training of personnel for effective programs.

Q. 14. Are there limitations on the provision of family planning services to individuals in terms of eligibility in either Medicaid or title IV-A in terms of comprehensiveness of services? Coverage of drugs?

A. 14. We are fortunate in California that we have one of the few most liberal State programs under Title IV-A. We expect to be able to work out a fairly good arrangement under the Medicaid program. However, there are still limi-

tations to the percentage of our patients which can be served through these programs. Nationally, Title IV-A and Medicaid are currently administered under such a hodge-podge of individual State eligibility requirements and regulations on services and drugs that I believe it will be very difficult to accomplish a significant expansion of family planning services using these two funding mechanisms, at least in the near future.

Q. 15. Do you feel that utilizing Medicaid and title IV-A authorities solely for expansion of programs will answer the interests of and concerns of minority groups?

A. 15. I believe that for minority group interests and concerns about family planning services to be answered we must continue to provide a comprehensive, totally voluntary service to all those who want them and need them but cannot afford them, regardless of a patient's ability to meet strict income-related or welfare-related characteristics. To target services expansion strictly on the AFDC mother is to hint at a desire to limit the family size of only those women rather than to demonstrate a motivation to help all women and men control their own fertility as present project grant programs do. Such focusing on the AFDC mothers can only produce resentment on the part of those dependent on the State for support and, in areas where minority groups comprise the bulk of those receiving AFDC payments, can lead to charges of genocide. I do not think this a healthy or desirable direction for the programs and that is why I support continuation and expansion of the Title X project grants as proposed in S. 1708.

QUESTION NO. 12 ATTACHMENT

The National Center for Family Planning Service Training efforts were initiated two years ago in 1971 with \$1 million in training contracts. In FY-72 the same level for contracts was continued with an additional \$2 million available for training grants.

The objectives of the training plan are designed to support the mission of the NCFPS in making comprehensive family planning services rapidly available to all such persons desiring such services. To assist in assuring high quality services, the NCFPS strategy is to encourage the maximum effective utilization of all existing categories of personnel and the introduction of new or previously unused types of paraprofessional/paramedical staff. It has been estimated in the "Five-Year Plan" that the total staff needed, both full and part-time, will be in the range of 97,000 which includes 6-8,000 physicians working a limited number of hours per week. Approximately 5,000 family planning staff will be trained in FY-72 as a result of NCFPS training support.

Job Categories.—Physicians, Nurses, Administrators, Outreach, Clinical, Health Educators, and Hospital Staff.

This training is being provided through short-term training programs designed to meet the training needs of service projects staffs.

These objectives were implemented through the FY-72 funding which was made to 23 grantees and contractors on a national level with three primary focuses:

- (1) to provide direct training through regional training centers or state and/or local training sites;
- (2) to provide specialized training to update the roles of occupational specialties in family planning such as physicians and nurse-clinicians and to develop such new categories as family planning specialists;
- (3) to provide a training capacity in those areas where a professional staff trainer is not available and to broaden the range of training by a train-the-trainer methodology.

The attached sheet lists NCFPS grantees/contractors.

Title	Amount	Description
Grants:		
Beth Israel Hospital.....	\$24,527	Training physicians in family planning.
Boston Family Planning Project.....	33,236	Training all levels of personnel in family planning in the State.
Planned Parenthood/Vermont.....	25,000	Development of testing training materials and methods for use in family planning programs in rural areas of Maine, New Hampshire and Vermont.
New Dimensions in Comprehensive Health..	212,000	Providing training seminars to project personnel; providing training and technical assistance to all levels of family planning staff, includes team building, skill development, outreach, counseling, technical services, human sexuality, consumer participation; management and administration.
School of Public Health, Medical Service Campus, University of Puerto Rico.	106,270	Provides training for supervisory personnel in basic principles of training; introduce and practice training techniques not commonly used on island.
Planned Parenthood Association of Maryland, Inc.	313,200	Training Institute provides training necessary for increasing and improving knowledge and skills in family planning.
Emery University.....	609,500	Continue development and implementation of strategy for family planning training to encompass all categories of family planning personnel, using staff facilities of grantee.
Planned Parenthood Association of Wisconsin.	54,000	Provides education and training in family planning to nurses, paraprofessionals, community health workers, family planning clinic and agency directors, teachers and youth counselors.
Indiana Family Planning Training Project..	81,000	Training of family planning personnel, management, nursing, outreach, clerical and social services.
Planned Parenthood Association of Columbus.	108,000	Short term training in family planning administration, communications, clinic operations and management to family planning staff and volunteers.
University of Kansas Medical Center.....	78,871	Training nurse-clinicians.
Nebraska Family Health Association.....	97,510	Training of family planning project staffs to improve quality of service to all patients.
Nebraska Family Health.....	15,000	Provide mechanism for upgrading physician knowledge re permanent and temporary sterilization techniques.
Los Angeles Regional Family Planning Council.	67,150	Continue management institute; train-the-trainers; consumer council training; allied health professional training.
Attending Staff Association, Harbor General Hospital.	75,032	Training of female health maintenance specialists, formerly known as family planning specialists, who serve as physician's assistants.
Planned Parenthood of Seattle, Inc.....	111,433	Short term training in family planning skills, knowledge and attitudes to selected nurses, physicians, counselors, administrators, paraprofessionals, clerical personnel and volunteers.
Contracts:		
Michigan Department of Public Health.....	92,960	Workshops toward improving skills of professional and paraprofessional personnel in family planning in rural communities in Michigan.
Planned Parenthood of Minnesota.....	75,430	Training in component areas of family planning to enhance skills and knowledge of current and new workers in family planning throughout Minnesota. Training includes anatomy, birth control methods, human sexuality.
American College of Obstetrics and Gynecology.	283,687	Selects and provides technical assistance to 5 medical institutions providing education in obstetrics and gynecology in order to develop training programs in family planning medical services. Develop curricula for family planning physician programs. Curricula encompasses all pertinent facets of family planning interconceptional care.
Urgan Research Group.....	140,000	Provide staff of family planning project with basic and advanced family planning orientation, education and skills. Training directed to pre- and in-service training of paraprofessionals and professionals with regard to reproductive physiology and methods of birth control.
Development Associates.....	174,900	Train family planning administrators in management skills and for development of administrator's manual and creation of regional communications system between grantees.
Do.....	157,340	Development of training programs tailored to needs of nurses, outreach workers, physician and other individuals designated as family planning trainers working in family planning programs.

Senator CRANSTON. Our next and final witness is Dr. Raymond Vande Wiele, chairman of the Department of Obstetrics and Gynecology, Columbia University.

Dr. Vande Wiele, we welcome you.

STATEMENT OF DR. RAYMOND VANDE WIELE, CHAIRMAN, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, COLUMBIA UNIVERSITY

Dr. VANDE WIELE. Thank you, Senator Cranston. I have submitted some written testimony which I would like only to summarize in this oral presentation.

Senator CRANSTON. The full text of your statement will be included in the record at the conclusion of your testimony.

Dr. VANDE WIELE. I would like to limit my comments in fact to those that treat with the subject most relevant to me as chairman of the department of obstetrics and gynecology as well as director of an institute devoted to the study of human reproductive function.

As a result of the drastic curtailment of research funds and the virtual elimination of training programs in this field, I think the impact of an extension or lack of an extension of the law that we have under discussion must be considered in the light of this panic.

For many years, progress in our understanding of human reproduction function has been much slower than that made in other medical disciplines. There are many reasons for this relatively slow progress not the least of them the fact that research in the area of reproductive function has been mainly based in the departments of obstetrics and gynecology which traditionally have been devoted to research less firmly than other major medical disciplines.

Thanks to the steady input on money in the last 10 years there has been an enormous upsurge in our information about human reproductive function. However, even now, if I may quote from the testimony of Secretary Richardson—and this quote actually goes back to 1971—there had been a major influx of new money in this field, yet Secretary Richardson felt it necessary to say:

• • • In spite of its transcendent importance to human existence, reproduction has received relatively little scientific attention. Even with today's concern for the population problem, the most talented among young investigators all too frequently seek other subjects.

This is the main problem that we are facing at the present time with the contraction in money and scientific research. The contraction may be first felt in those fields that are less well established, such as the fields of reproduction, the study in obstetrics and gynecology.

Let me just give two examples that relate to my own problem as a director of an institute of reproduction.

Five years ago this institute started with a major grant from the Ford Foundation. In the grant was included \$2.5 million for a building, the understanding being that the building funds would be matched by Federal funds. We applied for Federal funds.

The application was approved with high priority, however, when funding time came around all building funds for health research facilities had been eliminated, and we had to start without the matching funds.

Similarly, recently NIH started an important program which I think was an extremely important program in this field; the plan was to create a number of centers for population studies. Again we applied for this, we were visited by a scientific review committee, we were approved with high priority, and again because of the curtailment of recent funds, this grant will not be approved.

This is the experience of most major research institutes. It is becoming increasingly difficult, in view of this experience, and in the light of the fact that fluctuations in the last 10 years, to find funds; indeed our funds have gone down to a trickle. At the present time there is a reverse because of the emphasis on programs such as heart, cancer, and so on.

I think I will come back in a minute to some of the important basic research in this field, but I would like very briefly to comment about the roles of the universities in fertility research.

Virtually all major research in reproduction and fertility control at the present time is carried out by the major universities. There is only one research institute of significance outside the universities.

The pharmaceutical companies were interested in the beginning. At the present time the incentive is not sufficient for them to go on, and most of them are phasing out their studies on fertility control.

The Ford Foundation, generally speaking the private foundations, also are not increasing their interest in problems of reproduction because they feel that they only have to start, and that they should now turn to other problems such as ecology, poverty, minorities, and so forth.

In view of the general contraction of funds for the universities, there is increased emphasis on medical services in the schools. The universities feel that they cannot just expand their efforts in acute activities; and, again, universities are emphasizing more surgical problems, medical problems, rather than problems of reproduction.

This disenchantment with reproduction problems comes at a very bad time. I know that the agency directly involved in the operation of family planning would not like to talk about it, but I think in the scientific word, there has been a general disenchantment with the methods of contraception that we have at the present time.

The two mainstays, the pill and the IUD, are definitely not the answer. We know in most programs 2 years after a person has started either on a pill or has used the IUD, only half of these patients are still using these methods. So we need new methods.

At the present time virtually all of the contraceptive methods have come about not because of research specifically carried out because of interest in population. The methods are described in my written testimony.

However, none of these methods are even ready for clinical trial. Some of them are almost ready for a clinical use, but general use is off 5 to 10 years. This is why I think at the present time the contraction we have in research is virtually catastrophic, because if we are 5 years off with adequate funding, we are much further off with inadequate funding.

In this respect I want to come back to what we call the catastrophic elimination of funds for training particularly in reproduction.

I would like to emphasize that I think there must be specific assignments for money in reproduction because if there is no specific

assignment for money in reproduction, universities will put their priorities where they are the most important for the universities as a whole, and not necessarily in terms of population growth.

In this respect I think that the creation of a National Institute for Reproduction or for population problems, whatever you want to call it, I think would be very important.

There is one final remark I would like to make which deals with the administration. I would like to enter this area because I am unfamiliar with the administration at the Federal level. It is my understanding that this bill would take all reproductive research out of NIH.

I have had a great deal of experience with NIH. I have served on many study panels. I have the greatest respect for the way in which priorities have been set and funds have been distributed, and would certainly like to make a plea for the retention of the peer review system in assignment of funds in operation at the present time at NIH.

Senator CRANSTON. Thank you very much, Dr. Vande Wiele.

Could you tell us what are some of the difficulties you have encountered concerning Federal funding for all your investigations through the Center for Population Research?

Dr. VANDE WIELE. As I mentioned before, we submitted an application, the application was approved with high priority, however it was not funded because of lack of funds.

You may be aware of the origin of the centers. A program was started with separate funding. Then later when money became more tight, the centers were considered to be part of the general research program, so that the centers compete with the individual grants, and in this fashion very often cannot get sufficient priorities to be funded.

I think the idea of the reproduction centers is an excellent one.

Coming back to the matter of universities, the universities will not start programs unless they are reasonably certain of funding or support for a significant amount of time. As you well know, I am sure, the universities all have a tenure system, and unless we can promise to the people in the centers support for 5 years or even more, we will only attract second-class people.

Senator CRANSTON. You pointed out that traditionally this research has been a low-priority item residing mainly in obstetrics-gynecology departments of hospitals. How can we make reproductive physiology research more attractive to scientists?

Dr. VANDE WIELE. I think by assigning specific funds to reproduction, not making them part of the general research budget.

Perhaps even more importantly we could do this by creating a specific agency devoted to problems of reproduction, and an agency that not only would not be a visible expression or symbol of the interest of the Government into problems of reproduction, but also could defend the activities of the departments of obstetrics and gynecology.

Senator CRANSTON. Could more funding be used properly in this field?

Dr. VANDE WIELE. Oh, yes. I think at the present time the funding—obviously I cannot give you exact figures—is clearly insufficient. I could name you a number of research groups that actually have gone out of business or are going out of business because of lack of support.

Senator CRANSTON. So there are some unmet needs right now?

Dr. VANDE WIELE. I think that the support that actually was suggested in the original 5-year plan of HEW for 1974 would come to \$100 million which would certainly be a reasonable figure.

Senator CRANSTON. Could you give us some idea of the centers' concept?

Dr. VANDE WIELE. The advantage of a center is, No. 1, it is a clearly designed organization. No 2, it will have cost support which makes it possible to fund various groups inside the center.

As an example, in the institute that I am director of we have specific funds for the luteolytic approach. None of the research groups can afford this. We have support for statistics. Again, none of the individual groups could do this.

I think the centers concept is an extremely important one. I would also like to emphasize what I have said before. It would assure the people involved in the centers a reasonable time of support, which would make it interesting for them to devote time to a specific study, rather than to general problems of research.

Senator CRANSTON. Could you give us a brief explanation of the significance of basic biomedical research in the population science field?

Dr. VANDE WIELE. Yes; that is easy. As an example, what are the three major new possibilities for contraceptive research? One is prostaglandins. This was discovered by a Swedish investigator who was interested in substances present in various tissues that had contractual effect on blood vessels. At this moment it was completely unknown the substance which could be used.

The other example is that of hypothalamic hormones that are probably some of the most exciting in future contraceptives. Again this was the result of new research that had nothing to do with reproduction.

I do not think this general feeling of most investigators in this field—it is not worthwhile to look for a better pill. We need another pill. We need another approach, and this will only come from basic research.

Senator CRANSTON. What would you estimate as the amount that should be appropriated for extensive research in this field?

Dr. VANDE WIELE. As a means of controlling fertility? In rough figures—I would have to do more homework than I have done about this to develop figures.

I think there are several areas where more support is needed. I think there should be definitely the centers program, it should be expanded, and I think \$50 million would probably be needed for such a program for let us say the coming fiscal year.

The training program is critical because at the present time the amount of talent in reproduction is insufficient. I would guess the training program would require somewhere between \$3 million and \$4 million.

If my recollection is correct there is now for a total research \$35 million. I think it would be coming to the \$100 million that was suggested by HEW 3 years ago.

Senator CRANSTON. How much of that can be provided by medical research institutions?

Dr. VANDE WIELE. You mean from private funds?

Senator CRANSTON. Yes; from whatever medical research institutions can provide for that.

Dr. VANDE WIELE. I have the impression that the Ford Foundation, as an example, funds approximately \$10 million to \$20 million a year at the present time. The Rockefeller, probably one-half, and the other agencies other than AID, which obviously is not a private foundation, is very small.

It is my information that both agencies, both Ford and Rockefeller, have decided to decrease their involvement in reproductive research.

Senator CRANSTON. Without Federal help, how much would the medical research institutions normally carry on their own in this field?

Dr. VANDE WIELE. 10 percent.

Senator CRANSTON. How much money would be available by the pharmaceutical industry?

Dr. VANDE WIELE. Virtually nothing. The pharmaceutical industry funds, as an example, institutions such as Columbia or Harvard—it is probably less than a fraction of a percent of the total research budget, as far as I know, and I have a rather good relationship with the firms interested in reproductive research.

It will be less rather than more in the future.

Senator CRANSTON. Do you have an estimate of the numbers of approved applications for research in human reproduction?

Dr. VANDE WIELE. By NIH?

Senator CRANSTON. Yes.

Dr. VANDE WIELE. No. Obviously we would have to check with them, but I am sure my information is correct, at the present time it has no money for any new grants in reproduction, and the only way to generate some new money is what we have done. They have cut 20 percent to generate sufficient money.

Senator CRANSTON. What is the dollar amount of approved but unfunded grants? Do you know that?

Dr. VANDE WIELE. No. It must be at least three or four times, if not more.

Senator CRANSTON. What do you think the impact of the administration's cutback on training grants will be on research in human reproduction, in the provision of family planning services and research and population dynamics?

Dr. VANDE WIELE. We do not have to say what the effect will be. The effect is there. As an example, at the present time in all universities it is very difficult to find somebody who is willing to train further after graduation in research in human reproduction.

Senator CRANSTON. I would like you to look at a copy of the bill which will be provided to you.

Dr. VANDE WIELE. I have one here.

Senator CRANSTON. On page 12, line 6 it says:

Funds provided under this section or any other provision of law under any contract with a profit-making entity to support any contraceptive development research shall be limited to not more than 50 per centum of the total cost attributed to the research activity covered by such contract.

What is your view on that ?

Dr. VANDE WIELE. I would like not to answer whether——

Senator CRANSTON. Will you submit that for the record ?

Dr. VANDE WIELE [continuing]. Whether it is 50 or 40 or 60 percent. I think the funds should develop new concepts, that they put a very significant amount of their own money in there, but I would not like to put in the percentage.

Senator CRANSTON. Will you submit that for the record ?

Then on page 16, commencing at line 5, running all the way over to line 10 of the next page, there are requirements to protect the rights and interests of patients in research programs and requirements for guarding the use of experimental contraceptive drugs.

I would like to have your views on those provisions but perhaps we should get that in writing from you.

Dr. VANDE WIELE. Yes.

[The prepared statement of Professor Vande Wiele, with additional information referred to, follow :]

PREPARED STATEMENT OF PROF. RAYMOND L. VANDE WIEL, COLLEGE
OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY

My name is Raymond L. Vande Wiele. I am Professor of Obstetrics and Gynecology at the College of Physicians and Surgeons, Columbia University; I am Chairman of the Department of Obstetrics and Gynecology of the College of Physicians and Surgeons. As Chairman of the Department of Obstetrics and Gynecology I am chief of the Obstetrical and Gynecological Service of the Presbyterian Hospital, the Delafield Hospital, St. Luke's Medical Center, Harlem Medical Center and Roosevelt Hospital Center, all in the City of New York. I am also Director of the International Institute for the Study of Human Reproduction which is part of Columbia University. I would like to make some comments relevant to the extension of the Family Planning Services and Population Research Act of 1970. I will limit my comments to those areas of the Act which pertain to me as Chairman of a Department of Obstetrics and Gynecology and as Director of an Institute devoted to the study of human reproductive function.

I am sure this committee is aware of the virtual panic that has struck the medical scientific community as a result of the drastic curtailment of research support in the biological sciences and the virtual elimination of training programs in this field. The impact of an extension or a lack of an extension of the Family Planning Services and Population Research Act of 1970 must be considered in relation to this general contraction of research in the biological sciences.

For many years, progress in our understanding of human reproduction function has been much slower than that made in other medical disciplines. There are many reasons for this relatively slow progress not the least of them the fact that research in the area of reproductive function has been mainly based in the departments of obstetrics and gynecology which traditionally have been devoted to research less firmly than other major medical disciplines.

In the late 1960's, due to the increasing concern about the population growth, there had been a rapid increase in research support available to investigators in the field of human reproduction, at a time when, in fact, the expansion of research in other fields was slowing down or had even stopped. The attraction of such liberal support has lured many excellent investigators into the area of human reproduction and this influx of new and often first-class talent has resulted in a rapid progress in our understanding of the biology of human reproduction. Whereas a decade ago we knew more about the ovarian cycle of domestic animals, at the present time information about reproductive function in women is much more complete and in fact expanding almost exponentially. In a later part of my presentation, I will give some specific examples but I would like to point out clearly at this time that these advances in our understanding of reproductive physiology and biochemistry have led to suggestions of many new avenues in contraceptive technology, some of which may lead to real breakthroughs. Even after this new and gratifying influx of talent and as late as 1971, Secretary Richardson, while commenting about the Department of Health, Education & Welfare's 5-year plan for Family Planning Services and Population Research, felt it necessary to note that

"..... in spite of its transcendent importance to human existence, reproduction has received relatively little scientific attention. Even with today's concern for the population problem, the most talented among young investigators all too frequently seek other subjects."

Unfortunately the little and insufficient momentum that has been gained in the last 10 years is now in danger of being lost. Perhaps I may draw upon my personal experience as Director of the International Institute for the Study of Human Reproduction. This Institute was started with a very substantial

grant from the Ford and Rockefeller Foundations. Included in the grant was 2.5 million dollars to be used for the construction of a separate building to house the Institute. The understanding was that the 2.5 million dollars was to be matched by federal funds. In due time, the International Institute for the Study of Human Reproduction, at this time under the direction of Dr. Howard C. Taylor, submitted an application to the National Institutes of Health for matching building funds. The application was reviewed by a scientific committee and approved with high priority. The grant, however, was never funded since in the fiscal year in which the grant had to start, all building funds for health research facilities were eliminated. Fortunately, alternate quarters were found and the International Institute for the Study of Human Reproduction was able to develop its operations, but much precious time was lost and several of the planned activities had to be curtailed because of lack of space. The lack of matching funds from federal sources was also a disappointment for other reasons. One of the hopes of the Ford Foundation and the Rockefeller Foundation in adding a building fund to the original grant, was that the erection of a prestigious building solely devoted to the study of human reproduction would be a most visible symbol of the importance given by these foundations, Columbia University and the federal government to the problem of the population explosion.

Let me give another example of unfulfilled expectation. Three years ago, the National Institutes of Health decided to create a number of Centers for Population Studies to be supported in the fashion of the Clinical Research Centers. In the fall of 1971, the International Institute for the Study of Human Reproduction submitted an application for support under this new program. In the spring of 1972, a distinguished team of scientists made a site visit and the application was approved with high priority. However, no definitive

award was made because of the veto of the budget of Health, Education and Welfare. One year later in the spring of 1973, we were again informed about the approval of our application but the final award was postponed once more, and in view of the present budget situation, funding is becoming less and less likely. I would like to stress that in both circumstances, the scientific review committee had recommended approval of the application with a high priority and the lack of funding of the application was due solely to the fact that earlier financial commitments were subsequently curtailed. This history is typical of that of many other research organizations involved in the study of reproduction and this gap in credibility makes it increasingly difficult to attract to this field scientists of distinction.

Recently, Oscar Harkavy, Program Officer in charge of the Ford Foundation's Population Office, testified before the Task Force on Population Growth and Ecology. In his testimony he surveyed institutional arrangements and existing resources and financial support for fundamental and applied research in population sciences, including the role of public agencies, private foundations and pharmaceutical firms. His survey clearly showed that the primary locus of fundamental research and training in reproductive biology related to fertility control is in the universities. As an example, there is only one major research institute outside the university exclusively devoted to reproductive biology and contraceptive development. The pharmaceutical industry is increasingly reluctant to invest in this area because of the high ratio of risk to benefit to the firm. The role of the universities in fertility research is therefore crucial and any change in the priorities of the universities will have a direct and immediate effect on the amount of work carried out in this area. The decrease in research support in all medical disciplines has unfortunately made it necessary for all medical schools to review their priorities. At

Columbia and in other schools there is increased emphasis on medical services, for which long term support is assured, while there is a clear tendency to contract the research activities. Due to the same reason, the number of medical graduates who are willing to enter into a research career has dropped sharply and this drop is even more pronounced in the departments (such as obstetrics and gynecology) in which the tradition for interest in research is of more recent vintage and therefore less well established. Unless significant amount of research support will remain available in the area of fertility control, the medical schools will go back to their old priorities, a tendency which will even be accelerated by the recent emphasis by federal agencies on cancer and heart disease.

The threat of these events to future work in contraceptive development cannot be overestimated. As research support contracts, there will be an increasing tendency for the young bright graduates to go into private practice. Those remaining in research will be increasingly attracted to the more glamorous area of the "life-saving diseases" and human reproduction will go begging for talent.

In terms of fertility control, these developments come at a most inopportune moment. There is increasing disenchantment with the two mainstays of present contraceptive techniques: the pill and the intrauterine device. As an example, it is generally estimated that two years after opting for either pill or intrauterine device for contraception, less than one half and often only one third of the patients who originally chose a technique are still using it. The reasons for this general dissatisfaction need not be elaborated upon here, since they are widely known. Fortunately this disappointing development could be counteracted by the new methods of contraception that are now being developed.

The work of the last five years has greatly increased our understanding of the physiology and biochemistry of normal ovarian function. A better understanding of the factors that control normal ovarian function has led to the formulation of several new contraceptive approaches, some of which may revolutionize contraceptive technology. It may be of interest to discuss these in some detail and to outline how they differ from the classical methods of contraception. One of the main drawbacks of steroid contraception, as we know it now, lies in the fact that these steroids have to be administered for most of the patients' reproductive life. Since estrogen and progesterone exert potent effects upon many of the metabolic processes in the body (e.g., on carbohydrate, lipid and protein metabolism), long-term therapy with steroids may produce potentially dangerous alteration in the body economy. This disadvantage can be overcome by some of the newer approaches, in which it is only necessary to administer the contraception agent or agents (which may not be steroids) during only a few days of the menstrual cycle. This possibility became apparent after some recent work dealing with the fate of the egg following ovulation. Following ovulation the egg is captured by the oviduct, and fertilization occurs in the outer part of the oviduct. Following fertilization the ovum moves through the oviduct and enters

the uterus. At the same time the lining of the uterus undergoes specific changes which are necessary for the implantation of the ovum. It is crucial that the speed with which the ovum moves through the oviduct and the transformation of the lining of the uterus be perfectly synchronized and even small asynchronies will make implantation impossible. The transport of the ovum through the oviduct and the transformation of the lining of the womb are under the control of hormones secreted by the corpus luteum. As a result of recent work the factors controlling the synthesis and secretion of the hormones of the corpus luteum are now well understood and various means are being worked out to interfere with these processes. The substances that interfere with the normal function of the corpus luteum are called luteolytic agents and this approach to contraception is called the luteolytic approach. The patient takes the agent only for a few days at a specific time following ovulation and menses will occur at the normal time whether fertilization has occurred or not. Another obvious advantage is that this method of contraception would only have to be used in cycles during which intercourse has occurred. Since the luteolytic agents are to be administered only for a short time the side effects of such agents would be negligible. The method is very promising but a great deal of further research will be necessary before it can be applied widely. One such approach actually is already being used under the form of the "morning after pill" but this approach can only be used as an emergency measure and has many disadvantages which prevent its routine use. Essential for the success of the luteolytic approach would be methods that will pinpoint the date of ovulation more precisely than we can do now. The solution to this latter problem would also have important implications for those parts of the population that have to rely upon the rhythm method.

Another perhaps even more promising approach resulted from the discovery of hormones secreted by the brain that regulate reproductive processes. One of these - gonadotropin releasing hormone (Gn-RH) - is secreted by a part

of the brain called the hypothalamus and stimulates the release of gonadotropic hormones by the pituitary gland. The gonadotropins in turn stimulate the secretion of ovarian hormone. The hormone has a relatively simple structure and it has been synthesized in the test tube and should soon be available in virtually unlimited quantities. At this time the hormone has to be administered by injection, but administration by mouth should become feasible in the near future. Other than by stimulating the release of gonadotropins, the hormone has no biological effects and its administration therefore has none of the drawbacks of the administration of steroid hormones. There are various means by which the administration of Gn-RH could be used for contraceptive purposes.

One of the most promising would be the daily administration of the hormone in amounts to assure ovarian function at levels necessary to maintain secondary sex characteristics but insufficient to induce ovulation. The patient would be able to regulate her ovarian function at whatever level she desires, only to interrupt the treatment when she wants to conceive.

These two new contraceptive methods which have far-reaching possibilities are further examples of the serendipity of basic physiological and biochemical research. In both instances the first step was the clarification of the mechanisms controlling normal function which secondarily then suggested a new contraceptive approach.

I will only mention in passing some other approaches. Some recent work on sperm maturation outside the testis points to certain new sites of possible attack, so that sperm maturation would be blocked without interfering with sexual function. Up to now, all methods of contraception in the male while decreasing fertility also decrease potency and therefore were unacceptable.

There is a great deal of research, some of it very promising, on new methods of delivery of contraceptive agents. Some of these methods use plastic materials impregnated with a contraceptive which is released constantly at the desired rate. The plastic may be implanted under the skin or inserted into the vagina or even directly into the uterus. In the latter case, only very small amounts of steroids have to be released since they exert their effects directly at the site of implantation. In this fashion, side effects become negligible.

Finally I would like to make mention of new procedures for female sterilization which do not require abdominal surgery and which can be carried out within a few minutes in the doctor's office without general anesthesia. With the exception of the new methods of sterilization, none of the second generation of contraceptive methods are ready for general use or even in most instances, for clinical trials. Much research will be needed and this will require trained investigators and adequate financial support. At this time, the outlook is gloomy. Because of the uncertainties of adequate funding for research and even more because of the lack of training funds, the recent medical graduates are increasingly reluctant to enter into a scientific career. Private practice is much more tempting and does not leave them at the mercy of the changing moods in federal spending.

For research in reproduction, the future looks even bleaker. The pharmaceutical industry does not have a sufficient incentive to enter this field. The private foundations are switching their support to other pressing problems such as poverty, the minorities and ecology. The universities, finally, in which most of the fertility research is done are reconsidering their priorities. With a limited amount of federal support for research, the more "glamorous, life-saving" diseases are attracting the best and the brightest. If Congress wants contraceptive research to continue, it will have to make it attractive to the scientific community. A single transfusion of money will not do this but a well conceived, and more importantly perhaps, long-term program of training and research support. I would like to stress to this committee that otherwise the search for new contraceptive methods will be abandoned by those who are responsible for the advances made in the last years..

In conclusion, I would like to address myself to an administrative problem. Normally I would be reluctant to bring this up since I am insufficiently familiar with these problems at the level of the federal government. I know that the bill as written would take the responsibility for all contraceptive research out of the NIH. For many years, I have been a consultant to NIH and have served on all kinds of study sections and study panels. I have been enormously impressed by the efficiency with which these panels have functioned and with the wisdom and fairness used in assigning priorities for research. In fact, many of us feel that it is the peer review system in NIH that has been the most important factor in the excellence of American medical science. I would like to stress this fact to this committee and caution them against abandoning a system that has been so successful in the past.

I would like to thank you for giving me a chance to testify and I am grateful for your attention.

College of Physicians & Surgeons of Columbia University | *New York, N.Y. 10032*

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

630 West 168th Street

May 30, 1973

Senator Alan Cranston (California)
United States Senate
Washington, D. C. 20025

Sir:

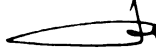
During my testimony before your Committee on May 8, 1973, you asked me to comment on lines 6 through 10 of page 12 of S.1708 and to give you written comments on lines 5 through 18 of page 16.

In my oral testimony I indicated that I was in agreement with the principle expressed in lines 6 through 10 of page 12 but added that I was uncertain about the exact percentage to be applied. Not without reason, pharmaceutical companies are increasingly reluctant to enter into new contraceptive developments since the lag time between initial laboratory studies and the commercial application of a new method may be many years (perhaps 10 to 15), and the expenses may run into the millions of dollars. The requirement spelled out in S.1708 may further deter pharmaceutical companies from engaging in new contraceptive development but I also feel it would be unreasonable to have the Federal Government bear the full burden of new contraceptive development. I wonder if a compromise should not be considered. The pharmaceutical companies take their major risk in the very beginning, at the time of the initial laboratory work and during the first phases of animal testing. Indeed at this stage it may be necessary to explore tens of leads before arriving at one that has commercial possibilities. On the other hand, once they get to the stage of clinical testing, the risks to be taken become more reasonable. I wonder if one should not consider waiving the 50% requirement for the initial stages of development (which indeed are more pure research and traditionally supported by Government) and apply the 50% only at the stage of clinical testing.

The need for informed consent and for a peer review procedure to make certain that the rights of the subject involved in the human experimentation are protected is one with which I am obviously in full sympathy. I'm worried however about the participation of consumers in the peer review procedure. First, one has to bear in mind that when talking about research with new contraceptive methods, the term consumers must be assumed to include children and possibly fetuses who obviously cannot be involved in the peer review procedure. It would also be quite difficult and in my mind unreasonable to involve adult patients in the peer review procedure. At Columbia-Presbyterian Medical Center, in accordance with the regulations of NIH, we have the stipulation that the human experimentation committee should not be exclusively composed of physicians or scientists but should be broadened to include people such as members of the supporting staff, of the social services, chaplains, etc. I am in sympathy with this type of broadening of the human experimentation committee and, in fact, favor this but I would oppose the inclusion of patients. For many years at the Columbia-Presbyterian Medical Center, we have been functioning under the regulations stipulated by NIH and I can bear witness to the fact that these regulations have been effective in protecting the rights and welfare of any human subjects involved in experimentations. Incidentally, you may be aware that there is, at the present time, a committee of NIH (chaired by Dr. Low of NICHD) which is looking into the problems related to human experimentation involving minors and fetuses.

I want to thank you again for allowing me the opportunity to testify before your Committee.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Raymond L. Vande Wiele', with a stylized, elongated horizontal stroke at the end.

Raymond L. Vande Wiele, M.D.

RLV/jg

Senator CRANSTON. In regard to the final comment in your prepared statement, you stressed the importance of peer review, and you said you wanted to stress this fact to the committee and caution against abandoning any system that had been so successful in the past.

I wanted to emphasize that we specifically included peer review in this bill for all research grants. Section 1004 (a) and 1009 (d) and (e) cover that point.

Thank you very much. You have been most helpful. I appreciate your presence.

We stand in recess until 8:30 tomorrow morning.

[Thereupon, at 4 p.m., the committee recessed, to resume at 8:30 a.m. the following day.]

FAMILY PLANNING SERVICES AND POPULATION RESEARCH AMENDMENTS OF 1973

WEDNESDAY, MAY 9, 1973

U.S. SENATE,
SPECIAL SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

man, presiding.

Present: Senator Cranston.

Committee staff members present: Jonathan R. Steinberg, counsel to the subcommittee; Louise Ringwalt, research analyst; and Jay Cutler, minority counsel.

Senator CRANSTON. The hearing will please come to order.

This morning we continue hearings on S. 1708, the proposed Family Planning Services and Population Research Amendments of 1973.

The subcommittee met, pursuant to recess, at 8:37 a.m. in room 4232, Dirksen Office Building, Senator Alan Cranston, subcommittee chair. Yesterday we received the prepared statement of the administration, as well as a commitment from the administration that the 5-year plan update, report, which has been overdue since January 2 of this year, would be transmitted to the Congress in a day or so. We anxiously await fulfillment of this pledge.

No questions were put to the administration yesterday by the subcommittee due to the failure of the administration to provide its testimony to the subcommittee 24 hours in advance as required by committee rules. We are in the process of scheduling a time for questioning the administration on its testimony on either May 18, 22, or 23.

Yesterday we heard testimony from organized family planning programs, religious leaders, national organizations, and eminent specialists in support of provisions of S. 1708 and in strong opposition to the administration's proposal that the major burden of financing the provision of family planning services be carried under the welfare programs rather than under the project grant authorities of title X of the Public Health Service Act, which S. 1708 proposes to extend and expand.

Although I look forward to questioning the administration on this approach, I must say at this point that I am extremely concerned about the apparent underlying philosophy that Federal Government participation in the provision of family planning services be ultimately limited to welfare clientele. Such an approach attempts to walk a highly tenuous and perilous tightrope between the need for services for those who cannot afford them, on the one hand, and on the other, the great concern that exists in the minority groups and poverty communities that some people have a hidden agenda for Federal involvement in the provision of family planning services—namely, “family planning is fine for the black, the brown, and the poor, who already drain too much of our economic resources in poverty programs, welfare payments and services, and other special programs”.

I categorically reject any such agenda—hidden or otherwise—and any such philosophy.

Although I agree that our primary obligation is to get quality services to those who can least afford them, I cannot endorse a policy which identifies the major Federal family planning effort with the elimination of poverty and the public assistance program. I recognize that these sorts of distinctions are not easily made. In many respects it is a question of tone and program emphasis. But the underlying point is of critical importance, and we must not lose sight of it merely because it is a complicated problem not susceptible to facile resolution.

With the witnesses today I want to state because of some rather stringent time problems we will not ask as many questions as we would like verbally, but will submit some in writing for responses for the record.

We will proceed with the first witness this morning being Mr. Robert B. Wallace, cochairman, Population Crisis Committee.

Mr. Wallace, we are grateful to you for being here so early.

STATEMENT OF ROBERT B. WALLACE, COCHAIRMAN, POPULATION CRISIS COMMITTEE

Mr. WALLACE. Senator, I welcome and appreciate this opportunity to speak today about the extension and strengthening of title X of the Public Health Service Act. Before addressing some of the provisions of S. 1708, I wish to give you some idea of what brings me to appear before you. I am new with the Population Crisis Committee, full time and unpaid. I came from a quarter of a century experience in the business community—agribusiness and agrigenetics. I sold my business in Pennsylvania to make a commitment and to join Gen. William H. Draper, Jr. and others who are working urgently for population stabilization in all parts of the world. I made this commitment, not because I think any of the serious problems facing this society or any other will be solved by a stabilized population, but because I think that virtually every problem that plagues us today becomes more difficult to solve because of population growth—problems such as poverty, pollution, hunger, crime, injustice, alienation, resources depletion, as well as tensions and instability at every level from international down to the family. There is no end to the list. Population growth underlies other problems of society in a way no other factor does.

Accordingly, I fail to see any other effort, any other investment opportunity for the private sector of government, either here or abroad, that is so basic to the questions of whether our children and those of other nations will have a reasonable chance to enjoy the freedom, the standard of living, and the options which we enjoy today. With that preface, needless to say, I am here today to support wholeheartedly S. 1708 which will continue and expand the very successful program initiated 3 years ago under title X of the Public Health Services Act.

I do so because the Family Planning Services and Population Research Act of 1970, or title X as it is more commonly known, has had a priority and rationale that surely is most exceptional. This has been recognized by the Senate which passed the original act unanimously, by the House of Representatives which passed it overwhelmingly,

and by the President who has expressed on a number of occasions deep interest in population and family planning affairs. In fact it was the President in his 1969 message who set the stage for the present act.

Legislation means little if it is not effectively implemented. The record here for federally subsidized family planning project grants within the 1970 act, however, is remarkably good. According to a study prepared by Planned Parenthood for the Department of Health, Education, and Welfare, in the first 21 months of the program about one-half the target group of low-income women and women at high risk of unwanted and health-threatening pregnancies utilized Federal family planning programs. Would that all of our other tax dollars performed so well when measured against objectives. We are dealing with one of the most constructive and successful public laws passed by Congress in recent years.

In tennis they say "never change a winning game. Always change a losing game." Surely this makes common sense for Government programs as well.

It strikes me that the single most important element in keeping a winning program going is that the funds for family planning and population research be categorically mandated. This program—or for that matter any other program that has even half the track record, logic, and benefits which this program has—is too important to be put up for grabs, for the pulling and hauling, both emotional and political, that occurs when there are limited funds and many worthy, needed programs are competing for them. The President himself put his finger on it when he said in his 1969 message to Congress that under the legislation then existing and I quote: "Requests for funds for family planning services must often compete with requests for other deserving health endeavors." To avoid this situation, the Congress mandated categorical grants with a specific goal and a 5-year plan to reach that goal. When we are halfway to that goal I think it would be irresponsible to throw away the plan and slacken our commitment to allow equal access for all American women to family planning information and services without regard to their income level.

I think that allowing title X to lapse would be both fiscally and programmatically irresponsible. Let me explain. I am impressed with the convergence on the one side of society's—indeed civilization's—absolute and urgent need for a maximum reduction in population growth through voluntary means and, on the other side, the simple justice and humanity, which I cannot believe anyone can contest, and which is implicit in the President's words: "No American woman should be denied access to family planning assistance because of her economic condition."

As a businessman though, I am also impressed by the dollar sense which federally subsidized family planning projects grants make. Here then, is another remarkable and startling convergence: that of the wishes of individual couples to plan and space their families with each taxpayer's wish to reduce public expenditures where possible.

A study prepared by the Center for Family Planning Program Development of Planned Parenthood under the direction of Frederick Jaffe demonstrates that the entire annual cost for federally subsidized family planning service programs is returned at least twofold in savings in the following year to Federal, State, and local governments.

Let me repeat, this occurs because Government is not called upon to underwrite hospital delivery and pediatric charges for births which do not occur and because welfare expenses are not swelled by births which do not occur. Granted it should be sufficient to justify family planning service programs strictly on their merits for both the family and society but at a time of budget ceilings and spending cuts, it is imperative that we do not reduce our commitment for reasons of "economy"—because that would be false economy.

Also, this study does not attempt to gage the longer term savings to Government for social services required by each child during the first 15 or 20 years of life. Education costs alone dwarf the initial medical and public assistance savings for each unwanted birth averted. We must also recognize that when unwanted children are born to low-income couples they often bring on emotional, health, and social problems to the family, the child, and to society.

I hope you will understand that I am not attempting to place the need for an extension of Federal family planning programs above the need for every other worthwhile Federal program. My point rather is that this has been one of the most successful programs initiated by the Congress in recent years and that it is perhaps unique in the extent to which it may lead to reduced needs for governmental outlays in both the immediate and the longer term future. This is something of great interest to every taxpayer. Indeed I have been inquiring—so far without success—to learn about any other program which returns far more than it costs in a 2-, 5-, or 10-year period.

The second reason why I believe that it would be irresponsible to allow title X to lapse is that the alternative will surely produce a varied and largely weak result. The alternative method, funding family planning programs under title 314e of the Public Health Service Act will assuredly weaken the commitment to meeting the need.

I believe that the present legislation, title X, and the proposed legislation, S. 1708, share a common strength in that there is clearly defined management responsibility for the program. Title X places the Deputy Assistant Secretary for Population Affairs in charge of conducting the Federal family planning program. S. 1708 would strengthen the control and elevate the position of the coordinator of the national family planning services and population research program to a new post as Assistant Secretary for Family Planning and Population Science. This strengthens the management of the program. After all, the 5-year plan and the annual updating required by both the present legislation and S. 1708 are a most effective means of checking on the progress in meeting our goals. The 5-year plan is a model which has been emulated in other health programs.

If we rely upon title 314e to fund family planning programs, we cannot be certain how much of the total funds available under this authority would be used for family planning project grant programs over the next year. Unlike S. 1708, no increase would be assured. If the administration proposes to make the State and local governments fund the difference then we will face a whole new set of problems. The history of State and local institutions in family planning is disappointing. Only 18 States have appropriated any State funds in family planning, even local communities which, after all, are close to the people can be hardly relied upon to see the importance of family

planning programs. Bucks County, Pa., which is where I live, is a good case in point. Bucks County is surely one of the most enlightened around in both people and government. Yet in 1972 the county appropriated over twice as much for mosquito control as for family planning, despite the fact that only about 40 percent of the low-income women in Bucks County who need family planning services are receiving them even after taking into account federally subsidized services already available.

A national program is the only practical way to deliver on a commitment to meet the unmet needs of women seeking family planning services and information and it does not mean nor has it meant, in practice, a large centralized program run out of Washington, D.C., and removed from the interest and concerns of consumers. Quite the reverse has occurred. There is a Federal commitment of funds but they are made available to local, public and nonprofit entities on a participating basis to fulfill local aspirations and needs. This seems to me the ideal way to deal with family planning services in view of the high probability that most States and local communities are not prepared as yet to make the necessary commitments of funds for family planning programs.

There is still reticence among some businessmen to endorse family planning service programs and eventual population stabilization in the United States. I think that is changing. The conclusion of the report of the Commission on Population Growth and the American Future states that "From an economic point of view, a reduction in the rate of population growth would bring important benefits, especially if the United States develops policies to take advantage of the opportunities for social and economic improvement that slower population growth would provide."

Many businessmen are taking an active interest in population policy. Let me cite a recent example. Recently the National Commission on Materials Policy, established by the Congress in 1970, organized eight forums across the Nation to allow businessmen, community leaders and educators to express their views on our national resource situation. Their report "very strongly supported" zero population growth because and I quote "any progress that can be made in other areas like resource management or environmental enhancement will be vitiated if population continues to increase."

Mr. Chairman, I think that it is important to renew title X by enacting S. 1708 for two other reasons, reasons that have great international implications—reasons that leave great international implications.

The United States has always exercised a leadership role in the developing of international interest in family planning and population programs. As you know, great progress has been made in world understanding of the threat posed by rapid population growth in the developing countries. In September of last year the Secretary-General of the United Nations, Mr. Waldheim, declared 1974 to be world population year with a World Population Conference to be convened in August 1974. This conference will be an historic first for the nations of the world to get together to discuss their common population problem. Out of it, hopefully, is to come a world population plan of action designed to encourage a slowing down of world population growth

rates. This conference will truly be a milestone event reflecting the hopes of the future and the successes of the past.

The successes to date lie in the dramatic international start that has been made. The United Nations Fund for Population Activities and the International Planned Parenthood Federation, both of which receive substantial support from U.S. foreign assistance funds, have grown remarkably in recent years. Starting from scratch 3 years ago, the United Nations Fund in 1972 exceeded \$30 million. More than 50 nations, both rich and poor, have supported the U.N. Fund, while 72 nations have asked for and received grants from the Fund.

During this same period, the International Planned Parenthood Federation has added 30 new members—bringing its total membership to 81 private national family planning programs, while its annual budget has grown from less than one million dollars in 1965 to over \$30 million this year.

Mr. Chairman, I mention this background because much of the strength of the U.S. leadership position in the international population field comes from the strength of our domestic family planning program. We cannot hope to continue to exercise leadership abroad unless we continue a strong program at home.

The second worldwide implication of S. 1708 is population research. It is a well-known fact that all of the presently available contraceptives have shortcomings of one sort or another in comparison with the type of contraceptive we need if we are to soon slow the world's population growth. The two most effective contraceptives—the oral pill and intrauterine device—have side effects so that not all women can use them. If we are to develop better contraceptives we need to undertake more basic research into the fundamental processes of human reproduction which are so inadequately understood.

Despite the domestic and international needs, population research has been sadly neglected. The budget of the Center for Population Research was only \$40 million in fiscal year 1972 and again in fiscal year 1973, with no increase in sight for 1974. Certainly the research program needs the kind of increasing support that is provided in the proposed act.

Mr. Chairman, in summary the Family Planning Services and Population Research Act has been one of the most successful health programs in our history and should certainly be continued by enacting S. 1708.

Thank you.

Senator CRANSTON. Thank you very, very much for your very helpful testimony.

Would you extend a little bit on the point you made toward the end relating to the relationship between our domestic commitment to family planning programs and our assistance to other nations, particularly those developing nations in their efforts to have family planning programs?

Mr. WALLACE. There is certainly in my view a very strong link between these two. I think this act gives substance to something that has come to be regarded as a basic human right.

President Nixon enunciated this very clearly in his 1969 message to Congress. This human right is the right of the individual woman to space and limit the size of the family. It takes a government to give

any meaning to this right. Here we have the 1974 world population year coming up. It seems to me that to drop at midstream a proven program, a program that is working beautifully, for one that is unproven in terms of its results, for one that is due to lapse in a year so we do not know what will follow, and which makes no commitment on increasing amounts as the present act does—to do this to me calls into question our motives as advocates of fertility control assistance measures before the rest of the world.

It would compromise our credibility as a leader in the world picture on family planning.

Senator CRANSTON. I appreciate your developing that point in which I concur very strongly.

What information regarding the type of contraceptives do you think need to be developed to meet domestic and world needs?

Mr. WALLACE. I would like to say there are two aspects of this family planning area in the developing nations as we see it, motivation and means.

Of the two, perhaps motivation is more important. But it is terribly complex. In every society, let alone in every country, there are differences and this is a difficult thing to get at and will take a long time to reach, and we do not have that kind of time. This is where means becomes so important. Because means involve biology and technology. What works for a woman in Uganda will work for a woman in Kansas, which means a dollar put to work arriving at an answer will soon result in a tremendous ability to apply them to the women who need them. I believe studies in many parts of the world show there is a difference between the number of children that are desired by a family and the number they actually have, and this is true in the world society where the average number of children desired might be 5, instead they get 7, 8 or 10, but there is this difference which generally occurs.

This difference suggests the need for a contraceptive method that can be applied down to the remote villages of the world.

There is a great need for one that is not only safe and effective, low cost, but requires a low threshold of motivation for its use. Ideally because of the shortage of doctors in the remote parts of the world, there is a need for a contraceptive method that is self-administered.

Senator CRANSTON. What should the role of pharmaceutical companies be in developing new contraceptives and bringing them to the market place?

Mr. WALLACE. I think they have a rather dramatic role. In this case there is, first, the urgent need for basic research in human reproduction. This is a role for universities. This is a role they can perform well and have in the past. But beyond that, if the universities develop new understanding, it somehow has to be brought down to the market place and brought down to a specific drug or a specific method that can then be merchandised. This is the role to me of the pharmaceutical houses.

Unfortunately, the requirements of the Food and Drug Administration have gotten tougher over the years. I should not say unfortunately to the extent that this is a greater protection to the consumer, but to the degree that the Food and Drug Administration tries to take on the role of the guarantor that absolutely nothing can go wrong, this has

added a number of extra years to the time required to bring a new product onto the market.

I understand that it now takes some 10 to 15 years to bring a new contraceptive onto the market, particularly, as a result of phase 2 and phase 3 Food and Drug Administration new drug testing requirements. A new contraceptive can easily cost a pharmaceutical company between \$8 and \$30 million before the company can begin to expect a return on its investment.

When you realize that the patent starts, I believe, in the first year of the development of the drug and then must run 17 years, and that a good many of those years, 10 to 15 of them, take place before the drug is put on the market, there is a very short time span left for the pharmaceutical house to recapture its overhead cost of that \$8 to \$20 million, or whatever, that has been spent, which means obviously that it has to load those charges into that very short time span, which jacks up the price of the contraceptive. Yet the contraceptive should be low in cost so that the public purpose is not defeated, which is to get a low cost contraceptive on the market as early as can be done with proper safety.

I tend to feel from this that there must be some way that industry and government can collaborate and perhaps a study needs to be made that would result in putting the cost of these lengthy studies, the second and third phase ones, more on the taxpayer than on the user. These costs do not really fall, it seems to me, on the pharmaceutical houses which after all pass it along to the user in product price. We want to see the product of this research brought down in cost, and if this is a public interest, it ought to be handled out of the taxpayer's money.

There is one extra concern I would like to mention, and that is that in any subsidy of industry, it seems to me it is important that this subsidy, if one is worked out, should relate to new methods developed and not to still additional contraceptives that are mere variations of those already existing.

Senator CRANSTON. Thank you very much. You have been a very helpful witness.

Mr. WALLACE. Thank you.

Senator CRANSTON. Our next witness is Dr. C. Arden Miller, professor of maternal and child health, University of North Carolina School of Public Health, and chairman of the American Public Health Association Action Committee; accompanied by Dr. Thomas L. Hall, deputy director, Carolina Population Center, University of North Carolina at Chapel Hill, both representing the American Public Health Association.

I welcome you. I know, Dr. Hall, you have been very helpful in providing us with information and analysis in connection with our development of this bill, and we are particularly grateful to you for that.

STATEMENT OF DR. C. ARDEN MILLER, PROFESSOR OF MATERNAL AND CHILD HEALTH, UNIVERSITY OF NORTH CAROLINA SCHOOL OF PUBLIC HEALTH, AND CHAIRMAN OF THE AMERICAN PUBLIC HEALTH ASSOCIATION ACTION COMMITTEE, ACCOMPANIED BY DR. THOMAS L. HALL, DEPUTY DIRECTOR, CAROLINA POPULATION CENTER, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, REPRESENTING THE AMERICAN PUBLIC HEALTH ASSOCIATION

Mr. MILLER. Thank you, Senator Cranston. It is a great pleasure to be here representing the American Public Health Association and to speak in support of Senate bill S. 1708.

Let me say a word, first, about the American Public Health Association. It is an organization of 25,000 members, representing a great many different professional groups, physicians, public health nurses, statisticians, many allied health science workers, et cetera. In addition, in recent years there has been increased participation and interest in the association by growing numbers of consumer representatives.

The American Public Health Association has a long record of support and interest for family planning efforts and population research studies. A landmark resolution was passed by the governing body of the association in 1959, and in the intervening years supportive explanatory resolutions have been passed and much testimony has been given.

I would like to cite especially the resolutions that were passed by the governing council of the association in November of last year at its centennial meeting at Atlantic City. Three resolutions in particular should be of interest to the subcommittee.

The first is entitled "continuation of Federal support for family planning services and population research." I will read that resolution:

In 1970, the American Public Health Association placed itself on record as supporting the establishment and expansion of family planning project grant programs supported by the federal government for the purpose of making available subsidized family planning services to all those desiring them. The last report of the Department of Health, Education and Welfare estimated that only approximately one-half of the 6.6 million women in need of subsidized family planning services in the United States would be receiving them through special projects for family planning services by the end of calendar year 1973.

For this and other considerations we have urged continuation and elaboration of the title X provision, as S. 1708 provides.

The second resolution is entitled "Provision of Fertility Related Services under National Health Insurance and Pre-paid Health Programs." This is an objective as we see it of bringing long-range benefits, making unnecessary certain categorical approaches that we believe to be critically necessary at the moment.

A third resolution calls for the establishment of a population science institute.

Furthermore, on behalf of the American Public Health Association, I would point out that we have gone on record specifically in opposition to the administration's proposal for funding family planning projects in the context of welfare benefits for many of the same reasons you indicated. We are opposed to merging high priority categorical programs into the 314(e) mechanism at this time. It is a concept which has attraction, but in other ways it seems to be a very fragile basket for some very important eggs.

We have prepared written testimony that we have made available to you. I would call at this time on Dr. Hall to summarize some of the high points of that testimony and then answer any questions you might have.

Senator CRANSTON. Thank you.

Dr. HALL. Rather than read the testimony, I would like to refer to some of the points that we make here and provide some additional clarifications with regard to them.

Starting on page 2, we have outlined some of the reasons we feel are most important in the achievements of family planning and population research legislation. The increase in the number of persons served during the past few years has been remarkable and half way through the 5-year span that was originally contemplated we are about half way toward meeting the original targets.

The number of unwanted births that have been avoided through this program has been substantial, although detailed quantification is not yet available.

Recent estimates indicate that about 15 percent of all births in the United States, and close to half of the births among the poor and uneducated are unwanted by one or both parents, giving thereby a measure of what needs still remain to be met.

The family planning programs have been very effective in promoting increased levels of health awareness, and the community orientation and outreach aspects of these programs have been striking.

The family planning program has been very successful, we believe, in reducing mortality and morbidity of mothers and children, and in the incidence of child abuse, particularly notable among families where the children were unwanted at the time of conception. Certainly one of the strongest points of the family planning program nationally has been that it is the best alternative to abortion, and even the proponents of abortion on demand are in agreement with the rest of the population that abortion is not a preferred method of fertility limitation. Only by strengthening family planning services can abortion incidence be reduced.

I would like to particularly call attention to family planning programs as innovators in the delivery of health care. During the past several years with these new programs, with the increased flexibility that these programs have had due to the lack of an established bureaucracy and a professional constituency that may act to slow down innovation, family planning programs throughout the country have introduced a number of very important health care delivery innovations.

There are two comments that I would like to make in regard to this. One is in relation to family planning manpower in which we have seen major emphasis on the downward delegation of functions,

and in this regard I would like to call attention to a number of very innovative programs around the United States. One of the most innovative is at the Harbor General Hospital in Los Angeles, and is concerned with training family planning nurse specialists which can effectively and economically assume many of the functions heretofore assumed only by physicians.

However, as I comment on the manpower aspects, I would like to call attention to the very gross inadequacies of the funding available for manpower development. For instance, in the Federal region IV of DHEW, in the Southeast United States, we have estimated that we need by 1975 some 500 to 600 family planning nurse specialists. At the present time available funds are adequate for training only 10 per year at the University of Mississippi. It is interesting to note in this regard the differences between what has happened in the United States, where we are spending about 2 percent of all family planning program moneys for manpower training and development, and the international programs which we are supporting in less developed countries where the average manpower expenditures vary between 10 and 17 percent of all program costs during the first few years of program development.

A second point I would like to make is in reference to the new administrative and organizational forms that are developing in the family planning programs, forms that we think have great relevance to the development of health care services generally. For example, in the southeast and certain other areas of the country, family planning programs are being developed in multicounty districts that were originally established by executive order in the late 1960's. Rather than have each local program funded at a level which cannot justify the sort of administrative development and evaluation staff that can insure good services, programs are grouped into multicounty areas and resources are made available for strong program support.

Lastly, in terms of the benefits of family planning, I would like to highlight briefly the favorable cost benefit ratio already mentioned by the previous speaker.

I would like now to direct my attention to the administration's proposal for funding family planning and indicate why we believe these are inadequate.

First, title IV-A and XIX cannot fund any more than a small proportion of program costs. I am director of a technical assistance program in the southeast United States, and I, along with my fellow consultants, have frequently encountered very difficult problems in trying to pry loose reimbursement funds through these two titles. We have had little success, and overall I would say only some 5 to 10 percent of the program costs, at least in the southeast, are now being met through these two titles.

I think it is important to mention that the administration commissioned its own study, submitted by a private contractor last March, on the feasibility of funding five different types of ambulatory care programs through these and other third party reimbursement mechanisms. The conclusions of this study, amply documented in more than 100 pages of the report, suggest that under the most favorable conditions only about 20 percent of total program costs—programs including family planning—could be covered under medicaid and title

IV-A. I think these findings contravene the administration's point in the testimony submitted yesterday to the effect that medicaid and title IV-A would be the principal ways of supporting future program growth.

Past experience with the use of section 314(e) of the Public Health Service Act has been very unfavorable, and I think nothing need be added to the very cogent remarks of Congressman Paul Rogers, in which he points out ways in which the administration has not used this section for the strong implementation and support of programs. Also, the administration's past failure to spend those funds which its own agencies determined were necessary for family planning services and for which Congress appropriated support, suggests the need to strengthen the legislative mandate for this program, rather than to loosen it.

In my last comments regarding the administration's proposals relating to family planning services, I would call attention to the fact that State and local governments have not yet given much priority to family planning. In our efforts nationally to get on with the task of program development, we have been somewhat delinquent in calling to the attention of State and local officials the many benefits of family planning services. This situation is being corrected, though we feel the programs still need more time to reach target levels and become visible to local decisionmakers before they can be cut loose from a congressional mandate.

I'd like to make several remarks in relation to population research. I was quite surprised, to say the least, at the very limited definition that the administration gives to population research as listed on page 13 of the testimony submitted yesterday. According to the administration, the mission of population research is to develop methods of fertility regulation which are safe, effective, and likely to be used and to understand the motivation for their use.

This extremely limited definition omits a number of very important problems which I think the Commission on Population Growth and the American future highlighted in its very excellent report of last year.

I would like to comment, first, on some of the problems in the administration's execution or implementation of population research, and then I will terminate with several remarks as to areas of needed research in the future.

The overall level of funding has been very inadequate during past years. It is interesting to contrast the recommendations of the Commission on Population Growth and the American Future with the administration's proposals. The Commission estimates that up to \$250 million annually could be spent usefully in three broad areas of research and training, as compared with the \$40 million now being spent by the Center for Population Research, and perhaps upward of \$20 million by other Federal agencies.

The administration has been very remiss in giving adequate attention to the development of population research centers. Three years ago the NIH initiated a program to bring together within population research centers the insights and methods of many different scientific disciplines in order to bring them to bear on population problems. In contrast with the funding that was recommended of at least \$15

million annually for population research centers as of this fiscal year, the total allocation for this category now amounts to only about \$2 million, with no increase in sight, and only five centers have been funded so far at a very low level of support.

Research training has been radically cut and this action is of course limiting our ability to train researchers with the new professional disciplines and the interdisciplinary backgrounds that will be required if we are to develop fresh approaches to the solution of population problems.

Problems of research focus are also evident. The administration's tendency has often been to give greater priority to the quality of the research design than to the importance of the research proposal or area to be studied, *per se*. If the proposals that are submitted do not address the most important problems, then the Federal Government should take action to insure that we develop and use a research capacity appropriate to these priority fields of investigation.

In conclusion, I would like to cite the southern growth policies board as an example of an important consumer of the type of new research that I am talking about. The southern growth policies board was created last year. It is an interstate compact that may eventually include up to 17 Southern States, and it is concerned with trying to promote qualitative improvement in the living conditions of the South. The board is keenly aware that the South's slower rate of development in the past may now be an asset; more alternative directions of population growth and distribution may still be available than is the case in the more developed North. The board is eager to gain and to promote the application of new knowledge about problems of population growth, of unwanted fertility and family planning, and of migration and population distribution. It needs the guidance of the Federal Government and other types of support in order to bring to bear its interstate planning mechanism for the promotion of a better South.

Some types of specific questions that the board is concerned with include: tax incentives and disincentives to move population to areas where it is desired. Transportation policy: should roads go where people are or should roads go where people should be? What type of labor force should be attracted? The South traditionally has tried to attract low-skill industries. Should this be continued, and how can the South control the rate of city growth? How can cities be kept at the quarter million size, rather than ballooning up to the multimillion size that exists in the North?

Let me conclude here, Mr. Chairman. Dr. Miller and I are appreciative of the chance to appear before you today in support of this bill.

Thank you.

Senator CRANSTON. Thank you very, very much. I deeply appreciate the testimony by both of you and your appearance and your help.

Dr. Hall, do you have a copy of the report you described in which the infeasibility of relying on medicaid and title IV-A for support of organized health programs was described?

Dr. HALL. I do not have it with me here, but I can provide it by mail.

Senator CRANSTON. If you would make it available for us it would be very helpful.

[The information referred to appears in the appendix on p. 397.]

Senator CRANSTON. I will pose these questions to either of you, for whoever chooses to answer, or if you both would like to comment that would be fine.

The administration, as you know, proposes to fund organized family planning services through the partnership for health authorities, to not extend title X of the Public Health Service Act and title V of the Social Security Act, and to terminate OEO programs. What are the implications of this proposal for organized programs to provide family planning services?

Dr. HALL. I think the implications are very severe. We have been working with a number of States in the southeast over alternative strategies, depending on availability of funding. Most of the State programs are already facing the likelihood of having to stabilize their growth, due to inadequate additional funding forthcoming through title X, according to present administration projections. In other words, additional program growth can only be funded through title IV-A and medicaid to the limited extent I pointed out earlier, and through greater economies in the delivery of services. We are finding these economies harder and harder to come by during the past several years, although there has been a modest reduction in the cost of serving one person for a year. This cannot go on indefinitely.

Senator CRANSTON. How many patients do you estimate organized programs can serve with the administration's proposed total project grant allocation of \$122 million in fiscal year 1974 for organized family planning programs?

Dr. HALL. The average cost that we have been working with, and it checks out fairly well across a broad variety of programs, is \$60 per person per year. At this rate, \$120 million would cover the cost of 2 million patients. We are already somewhat over 2 million patients being served. There are some additional State resources, local resources, and other funds that have been mobilized for the support of programs. But unless there is a major reduction in costs, which at this point I think could only come from a major reduction in the quality of care, I think that existing programs cannot pass much beyond 3 million.

Senator CRANSTON. Would this in effect mean reduction of the overall Federal share of project grant support?

Dr. HALL. My understanding is that the administration is not now proposing a reduction in overall support, but a maintenance of the present contract mechanism and the expectation that States will fund out of the third party reimbursement additional program growth. There are many of us, however, who doubt the administration will continue to maintain even the present level of funding and that indeed within a year or so we can expect to see categorical funding through project grants progressively reduced.

Dr. MILLER. I would like to comment briefly on the issues raised by funding this categorical program through 314(e). As you well know, the administration is proposing a number of other categorical programs to be funded in the same way. We as a health association find ourselves in a rather embarrassing situation of defending the categorical programs, when we would much prefer an emphasis on comprehensive health services which would cover all the present categorical health programs. However, we take this emphasis, believing that until we are assured that comprehensive health services can indeed be

Testimony of
C. Arden Miller
Thomas L. Hall
of the University of North Carolina at Chapel Hill
before the
Senate Committee on Labor and Public Welfare
Subcommittee on Human Resources

May 9, 1973

Senator CRANSTON. I thank you both very much. You have been most helpful. I appreciate your coming to the hearing.

We will be submitting other questions to you in writing.

Dr. HALL. Thank you.

[The prepared statement of Dr. Miller and Dr. Hall and the questions referred to and subsequently supplied, follows:]

Testimony of
C. Arden Miller
Thomas L. Hall
of the University of North Carolina at Chapel Hill
before the
Senate Committee on Labor and Public Welfare
Subcommittee on Human Resources

May 9, 1973

Mr. Chairman,

My name is C. Arden Miller of Chapel Hill, North Carolina. I appear here today on behalf of the American Public Health Association for which I serve as a member of the Governing Council and the Executive Board. The APHA represents more than 25,000 public health professionals and consumer members both in the public and private sectors. The Association is affiliated with public health associations in all 50 states. I am also a professor in the Department of Maternal and Child Health of the School of Public Health of the University of North Carolina at Chapel Hill, having formerly served as Vice Chancellor of the University for its health schools, and before that as dean of the Medical School of the University of Kansas.

I would like to present my colleague, Dr. Thomas L. Hall, also of Chapel Hill; he is Deputy Director of the Carolina Population Center and associate professor, Department of Health Administration in the School of Public Health. The Carolina Population Center is a large, university-based center concerned with the promotion of and support of training, research and service in the areas of family planning and population dynamics. Besides his regular duties at the University, Dr. Hall is director of a project funded by the National Center for Family Planning Services whereby technical assistance in family planning program development and management is provided to all HEW-funded family planning projects in the eight southeastern states. This testimony is presented jointly by Dr. Hall and myself and will deal directly with a number of issues.

We very much appreciate this opportunity to present our views on the proposed renewal and strengthening of the "Population Family Planning Services and Population Research Act of 1970", or Title X of the PHS Act. The APHA has a long record of support of family planning and population research, dating back to its historic resolution on population in 1959, and has on repeated

occasions given testimony before the Congress in favor of these activities. I would like to submit for the record three resolutions adopted by the Governing Council of the APHA at its Centennial meeting last November 15 relating to the "Continuation of Federal Support for Family Planning Services and Population Research", the "Provision of Fertility Related Services Under National Health Insurance and Prepaid Health Programs", and the creation of a "Population Science Institute."

In our testimony we would like to address separately the areas of family planning services and population research, and within each topic, highlight some of the reasons why the APHA believes that further strong support for these activities is essential. We will also review our doubts about the efficacy of the Administration's proposals for funding these activities as outlined in FY 1974 budget submitted last January, and by subsequent documents. We will illustrate some of our statements with examples drawn from our own State of North Carolina.

Family Planning Services

Of all the federal health initiatives in recent years, we believe few have proved to be so successful, so cost-effective, and so popular in such a short period of time as the family planning programs supported under Title X. We would like to review what we consider to have been some of its major accomplishments, either already in hand or well on the way toward achievement.

1. Increased number of persons served.

The number of low income persons served has risen dramatically during the past few years from less than one million in FY 1968 to more than 2.6 million by the end of FY 1972. The annual rate of increase has been over 35% during each of the past two years and if this is maintained, the President's goal expressed in 1969 of providing subsidized family planning services to the 6.5 million women estimated to be in need of them by FY 1975 can be reached.

2. Reduction in unwanted Births.

In the U.S.A. in recent years the total number of births per 1,000 population has declined gradually to about 15.6 in 1972. Although we don't know yet what proportion of this drop is attributable to federally funded programs, the impact is likely significant. Still, if all couples in our country averaged no more than two children henceforth, the overall U.S. population growth rate would not level off until well into the next century. Most important, however, is the problem of births unwanted by their parents which represent about 15% of all births in the U.S. and over half among the poor and uneducated. These cause much preventable human suffering and socio-economic loss, and are being brought down steadily with the help of public supported services. We know that actual family size preferences among the non poor and poor are similar, and this program truly makes possible equal opportunity.

3. Promotion of greater levels of health awareness.

The family planning program, because of its preventive and community orientation, is providing a needed point of entry for many low income persons into the health service delivery system. Rather than wait for persons to get sick, and then provide them with discontinuous and fragmented curative care, the family planning program seeks out persons in potential need of services, provides them with the information required to make a rational choice based on their own wishes, and then provides them the services as desired. In addition to providing family planning services, the program is also screening patients, and where necessary referring them for treatment for such conditions as cancer, heart and kidney and venereal disease, and sickle cell anemia, actions which at the same time promote health and help introduce the medically needy to the benefits of preventive health care.

4. Reduced mortality and morbidity of mothers and children.

By reducing the number of unwanted or ill-timed births, particularly among the poor, the family planning program is contributing to the substantial declines that are being observed in much of the United States in the morbidity and mortality of mothers and children, and in the incidence of child abuse.

5. The best alternative to abortion.

The provision of convenient, low cost, comprehensive family planning services is the only way of making abortion unnecessary. Years of legal restriction have provided an ineffective deterrent to abortion and even the most ardent proponents of "abortion on demand" are in agreement with the rest of the population that abortion is not and never will be the preferred method of fertility limitation.

6. Family planning programs as innovators in the delivery of health care.

An important but unanticipated benefit has been the impact of family planning programs on the innovation of health services delivery generally. Perhaps because of the relatively limited scope and complexity of family planning services, and lacking any long established bureaucracy or professional constituency, family planning programs have been leaders in the introduction and testing of new ways to deliver services such as the following:

a. The downward delegation of functions from physicians to nurses and other allied health professionals, and from allied health professionals to paraprofessional or indigenous health workers.

b. The use of outreach workers to bring the program to the community and to provide comprehensive patient followup.

c. The involvement of consumers in the whole process of program planning, development, management and evaluation.

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d. The development and operation of data systems for careful and timely program evaluations.

e. The decentralization of many aspects of program planning and policy formulation down to the regional and state levels, and of program administration down to the substate district level. These experiences will prove extremely valuable as the Administration seeks to promote the gradual decentralization of program operation in those health programs where this is appropriate. It is interesting to note that the southeastern states are now involved in an experiment whereby family planning programs are developed in the multi-county planning districts which were established nationwide by Executive Order in the late 1960s. The larger program size thereby attained can justify adequate program planning and support staff essential for the provision of quality services, while at the same time program decisions are kept close to the people being served.

f. The mobilization and use of third party reimbursement payments and local funds. Although local and third party payment funds are nowhere adequate to cover full program costs, the vigorous efforts of many programs to use these funds to the maximum is promoting a strong sense of local interest in and support for family planning.

7. The favorable cost-benefit ratio of family planning.

We've saved for the last the most tangible achievement of the program, its very favorable ratio of costs to benefits. Based on conservative assumptions about the number of unwanted births averted, and on the impact of these averted births on direct, first year savings to government at the national, state and local levels, it has been estimated that one federal dollar expended on family planning services will save between \$2.50 and \$2.90 in the following year alone.

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These savings represent government expenditures on maternal and infant care, and on public assistance and food stamps to those on welfare, and do not include savings accrued in subsequent years. Accordingly, the projected federal investment of \$802-906 millions during the FY 1973-75 period is estimated to generate a first year direct saving to government of between \$2.0 and \$2.6 billions. Much greater savings actually accrue from helping families space their children so they can achieve adequate nutrition, education, mental health, and economic productivity in later life. Tragically, studies have shown that among couples in the poverty group married five or more years, about 45% have five or more children, versus 15% in higher economic groups. Somehow we resist applying cost-benefit analysis to our decisions about social programs, but if the program is both good in its own right and presents such a favorable, cost-benefit ratio, it would be folly to not provide it with adequate funding.

Despite the impressive gains of the past few years, the amount of additional program expansion that must be accomplished remains great. Current estimates place program coverage at only about the half-way mark. Even if the level of unwanted births drops to only 10%, this would still mean that every year about 300,000 children are born who were unwanted by their parents at the time of conception, and most of these would be among the poor and near poor who want fewer children but are not reached by adequate information and services.

Our own State of North Carolina, typical of many of the lower income states of the South, presents a good example of how much must still be done. Although family planning programs are nominally in almost all of the state's 100 counties, less than half have well established programs with adequate federal funding. Strong, established programs such as the one in Guilford County, which encompasses the city of Greensboro, are now outpacing the availability of funds in their attempt to keep up with the rising demand for services, while the general shortage of federal funding has left many other counties and planning districts

with the extremely limited resources available from state and local government. Statewide, North Carolina is serving only about 25% of the women in need of family planning, and this proportion is typical of most of the rural South. As a result of this inadequate coverage, 37% of all births in North Carolina can be classified as of relatively high medical risk to both mother and infant. For example, in 1971 5% of all births were to mothers under 18 years old, 5% were to mothers over 34, 13% were out-of-wedlock, and 14% were of the fourth birth order and above. Where comparative studies have been made a close degree of correlation has been found between "high risk" births and unwanted births.

The Administration's Proposals for Funding Family Planning.

The Administration has proposed that family planning services be funded for the next three years, along with certain other health programs, under the provisions of Section 314(e) of the Public Health Service Act. It has also argued that the costs of future program growth be met largely out of third party reimbursements, notably titles IV-A and XIX of the Social Security Act. We strongly oppose both of these approaches for the reasons we have outlined below.

1. Titles IV-A and XIX cannot fund more than a small proportion of total program costs. Various studies have shown how inadequate these two titles are for covering more than a limited share of total family planning program costs. Programs vary widely from state to state as regards program eligibility, benefit schedules, service availability and accessibility. Although the Congress has now imposed penalties for states that do not provide family planning services and the federal:non-federal match has been improved, recent federal guidelines have largely negated the effects of these actions. Certain groups such as the working poor where the husband is present in the home and the unmarried have limited or no access to services. Under Medicaid certain elements of program

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expenditures such as manpower training and development, outreach, information and education, and program management and evaluation are hard to reimburse. The maximum income level has been set so low in many states that services are effectively denied to a large number of women who cannot be expected to pay \$50 or more annually for private care. A recent study done under contract for the Department of HEW on the feasibility of reimbursing expenditures for five ambulatory care programs including family planning concluded that even with a major effort by the Administration, this funding source could probably not exceed 20% of total program costs.

2. Past experience with the use of Sec. 314(e) has been unfavorable.

Congressman Paul Rogers, in his introductory speech for the proposed "Public Health Act of 1973 (H.R. 7274), described very forcefully the ways in which Sec. 314(e) and two other PHS Act authorities have been abused by this and previous Administrations. These sections are used either to undertake massive projects without the consent of Congress, or as an excuse for avoiding categorical programs which, once the enabling legislation is eliminated, are then downgraded or phased out. Quite aside from the doubts that may be expressed about the use of Sec. 314(e), the Administration's failure to spend even those funds which its own agencies determined were necessary for family planning services, and which Congress appropriated, suggests the need to strengthen the legislative mandate for this program rather than loosening it.

The APHA does not, however, favor special treatment for this program indefinitely. As the November 1972 resolution already submitted to you states, we propose that family planning become one of the constituent services offered under national health insurance and prepaid health programs. As soon as the nation has an assured health services delivery system, which gives proper emphasis to preventive services as well as curative ones, family planning should cease its categorical nature.

3. State and local governments have not yet given much priority to family planning. If the Administration's special health revenue sharing proposals are to work as regards family planning, there must be some assurance that states and local governments will give priority to continuation funding for family planning. Despite the evident success of family planning services from a national perspective, this new program still in a growth and development phase has not yet caught the attention of enough state and local officials to ensure its survival in the competition for scarce funds. As of FY 1972 some 23 states had appropriated \$3.5 millions through health departments and only \$828,000 through welfare departments for the support of family planning services for a combined total of \$4.3 millions. Even when the money is federal, as is the case with maternal and child health formula (Title V) grants to health agencies, the 50 states allocated only \$1.4 million more to family planning in FY 1972 than the \$7.9 millions that were federally earmarked for this purpose. In brief, the program needs more time to reach its target level, to refine and consolidate its operating characteristics, and to become visible to local decision makers before it can be cut loose from its Congressional mandate.

Population Research

The vital importance of a strong research program in the population sciences has been emphasized in many reports in recent years and should need no further elaboration. Suffice to note that the provision of family planning services, complex as that may be, is only one of many actions that bear on population growth, distribution, and characteristics. Only to the extent that we can understand the dynamics and determinants of population changes can we anticipate these changes, and to the extent deemed appropriate influence them in more optimal directions. Moreover, without a vigorous program of biomedical

research, our programmatic efforts to help people control their own fertility will be permanently handicapped with contraceptive methods that are neither fully effective nor safe. Our brief comments on the research area will deal with the overall funding level, need for population research centers, research training, problems of research focus, and the growing demands for new population research findings.

1. The overall level of funding. The Center for Population Research of the National Institute of Child and Human Development has, under the mandate of title X, developed a rapidly expanding program of population research and contraceptive development. However, this promising start is now confronted with a budget plateau in which expenditures have remained the same since FY 1972 and, after correcting for inflation, the FY 1974 budget request of the Administration will represent a significant drop in funds. Even more than has been the case in family planning, the Administration has been unwilling to request anywhere near the amounts that its own special advisory committees have recommended as necessary to achieve the President's goals enunciated in 1969, or even to spend the much lower amounts that were finally appropriated. According to the most recent and authoritative estimate of what could be usefully spent on population research and training, the report of the Commission on Population Growth and the American Future recommended last year annual expenditures in the vicinity of \$250 million* for three broad areas of activity, as compared with FY 1973 expenditures of about \$40 million by the Center for Population Research and perhaps around \$20 million more by the Agency for International Development and other federal agencies.

*Research and training in the basic science of reproduction, \$100 million annually; developmental work on methods of fertility control, \$100 million annually; social and behavioral research, \$50 million annually. The Commission recommended that as a start the federal government should allocate, for research, in 1973 the full \$93 million proposed for that year in the five-year DHEW plan, and that this level rise to a minimum of \$150 million by 1975. (The Report of the Commission on Population Growth and the American Future, p. 106.)

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2. Population Research Centers development. To understand more adequately the many complexities of population dynamics requires the concerted mobilization of the insights and methods from many different scientific disciplines in the biomedical, social, and administrative sciences. Fragmented and narrower research approaches have been responsible for serious gaps in our capacity for more effective responses to population changes in this country and in the world. This type of crucial and complex problem area has been effectively approached, in other cases, by utilizing institutions where the requisite variety of basic research talents are found, and getting them to focus on the area.

With this purpose in view, the NIH three years ago initiated a program to develop a set of major population research centers within selected universities and nonprofit institutions across the U.S. Careful initial planning indicated that this approach could, at relatively low cost, facilitate the application of some of the best minds of established scientists as well as of bright young students, to this field. It would require helping with the provision of shared, core research seminars, and research coordination efforts, and developmental activities especially in key areas of study.

This approach does not require building expensive new institutions, and has a very high benefit-cost ratio. It can bring needed focus and coordination to local research efforts. It can bring into the field needed new research talents unlikely to be mobilized through traditional contract and grant methods. It generates professional and institutional commitments to work in this field which last far beyond the availability of support from specific grants or contracts.

Unfortunately, this proposed program has only barely been initiated. Its history so far has been a great disappointment to many leading population

researchers, to say the least, and has indeed been a source of considerable demoralization. Although earlier, conservative projections anticipated a level of support of at least \$15 million annually for such Population Research Centers by 1973, the allocation for this category now totals only about \$2 million, with no increase in sight. Approved but unfunded proposals for support of such Centers come to a much higher total, and other Centers have simply given up applying. The available funds have so far been provided to six Centers, four exclusively in the biological research field, plus minor support to two others concerned with sociological studies. None have been helped to achieve the critical mass or the interdisciplinary breadth which should be the essence of this approach.

The House Republican Task Force on Population Growth and Ecology, among others, has particularly emphasized the need for advancing this component of the whole population research effort, noting its special value in encouraging innovative and imaginative experimentation at relatively low cost compared to other types of research support. It has observed that even the reduced projection of funds indicated in the HEW Five-Year Plan for population research in FY 1973 called for \$5.5 million in this category, less than half of which is now being made available. We feel that this component of the total population research strategy is perhaps the most fundamental of all, from the point of view of economy and potential short- and long-term benefits.

3. Research training. The radical cutoff of support for training of population researchers has dealt a serious blow to this whole field. It badly damages not only the U.S. but the worldwide population and family planning efforts. Unlike some other fields, the demands for qualified population specialists are very high, from universities, private groups, industry and official agencies at

various levels. Many key research frontiers have almost no one working at them. Help is essential to encourage top students to enter this field and to cover teaching costs, and is simply not available from other sources.

Especially serious is the crippling of innovative training efforts, aimed at applying new disciplines and fresh research approaches to population problems. For example, at our own institution, training programs which were established after a great deal of preparation and which were approved for NIH financing, but which are now left unfunded include the following: the first training program in the U.S. to prepare researchers to augment practical knowledge about the implications of population growth for governmental structures and public policies; the only training program in the U.S. aimed at preparing biostatisticians to work on better methods of population measurement and forecasting; the only program to prepare specialists in anthropology to clarify problems of acceptance of family planning and of population dynamics in different cultural groups; the only program of epidemiological research training needed to clarify the health effects of different population sizes and densities, and to help evaluate family planning program effects; the only program for researchers on psychological aspects of population change; and others..

4. Problems of research focus. While the traditional methods of more laissez-faire type of research grant support and committee review were more appropriate in times of ample budget availability, the population research field now calls for much more attention to priority setting and identification of key frontier areas, and for promotional efforts and risk-taking if necessary in order to cover these needs. Without further elaboration, this point also has implications for stronger and more systematic organization of the whole federally supported population research effort.

5. The Southern Growth Policies Board. Public awareness of population matters has risen remarkably, and new mechanisms are taking shape to represent such concerns and pursue their practical implications. A growing constituency will be pressing for answers which only stronger and broader population research efforts can produce.

An example of this is the Southern Growth Policies Board, an inter-state compact established last year which includes the Governors and other key representatives of the southern states. This group is keenly aware that the South's slower rate of development in the past may now be an advantage; more alternative directions of population growth and distribution may still be available. It takes a relatively fresh approach to future options. This group is eager to gain and to promote the application of new knowledge about problems of population growth, of unwanted fertility and family planning, and of migration and population distribution, as these will affect health, education, economic development, governmental effectiveness and social justice, physical resources, and other aspects of the quality of future life. Whereas scientific knowledge often outraces the means for its effective use, in this field we face a reverse situation where federally funded population research efforts lag far behind the potential demand.

To sum up, population and family planning concerns are obviously most fundamental to all aspects of future wellbeing for Americans. We strongly hope that the Congress succeeds in its quest for a renewed and expanded title X legislation, used to its full potential, to extend family planning services and population education and to strengthen population research.

We have enjoyed the opportunity to meet with you and share our views on these important matters.

RESOLUTIONS
Relating to Family Planning and Population Research

Adopted by the
Governing Council
of the
American Public Health Association
November 15, 1972

Continuation of Federal Support for Family Planning Services
and Population Research

In 1970, The American Public Health Association placed itself on record as supporting the establishment and expansion of family planning project grant programs supported by the federal government for the purpose of making available subsidized family planning services to all those desiring them. The last report of the Department of Health, Education, and Welfare estimated that only approximately one-half of the 6.6 million women in need of subsidized family planning services in the United States would be receiving them through special projects for family planning services by the end of calendar year 1973.

Since the job of providing services is only half done while the Family Planning Service and Population Research Act expires as of June 30, 1973, the American Public Health Association strongly supports the renewal of the Family Planning Services and Population Research Act of 1970 and the expansion to the levels called for in the DHEW Five-Year Plan for Family Planning Services and Population Research issued in 1971.

Provision of Fertility Related Services
Under National Health Insurance
and Prepaid Health Programs

APHA advocates the prompt adoption of a national system of health insurance which would place strong emphasis on preventive health services. We believe that the provision of fertility control services is fundamental to preventive health care and deserves the highest priority. We believe that any national health insurance proposal considered and adopted by Congress must reflect that priority and provide universal coverage of all fertility related health services to all who need them regardless of age, marital or economic status. At the same time, we urge that all organizations which provide health care on a prepaid basis include these services in their basic coverage of benefits to all persons enrolled under this plan.

Population Science Institute

Since its historic resolution on population in 1959, APHA has been a leader in national efforts for a greatly expanded federal program in population research. The existing institutional framework of federal programs of research in the population sciences has been shown to be unable to deal adequately with the size and range of population problems envisioned by APHA 13 years ago. Two years ago, this Association strongly supported S.2108, the Family Planning Services and Re-

search Act, which authorized a vastly increased research effort. At the same time, we urged that the Center for Population Research of the National Institute of Child Health and Human Development be strengthened to carry out its enlarged responsibilities. We recommended that it be placed at the equivalent level of an institute under the direct supervision of the director of the National Institutes of Health so that it would be better able to bring together and finance presently fragmented research and improve the character of present research efforts of the federal government. This recommendation has not been carried out and only a small portion of the funds authorized under the Act have been obligated for population research. This vitally important program must be provided with an institutional framework in which it can grow and command adequate resources. APHA urges Congress to implement the recommendation of the Commission on Population Growth and the American Future that there be established an Institute for Population Sciences in the National Institutes of Health in 1973.

The Commission on Population Growth and the American Future established by Congress and appointed by the President has recommended the creation of a special institute which should provide a stronger base from which this increased effort can be directed. It would facilitate acquisition of qualified personnel, laboratory and clinical space, and other resources necessary for a diversified program. It would increase the feasibility of the population research program, signal to the world that it ranks high among our research priorities, and should help in commanding the level of funding that we believe is necessary but which has not been forthcoming.

[Questions for Drs. Miller and Hall submitted subsequently by Senator Alan Cranston follow:]

Q. 1. The regulations recently issued on service programs by HEW specify that family planning services must be offered and provided promptly to all eligible individuals voluntarily requesting them. However, determination of eligibility is left to the State agency with a requirement that such determination be reviewed every six months after the original case by case determination required by the new regulations.

What are the implications of these regulations on the availability of family planning services supported by Federal funds to childless couples, to single adults, and to minors?

A. 1. The revised Title IV-A regulations make it very difficult to provide family planning services to childless couples, to single adults and to minors. Title IV-A provides assistance primarily to families in which the male head of the household is absent. In some states a very high percentage of first births to the poor and near poor are illegitimate, and even though the general birth rate has been declining in recent years, the illegitimacy and venereal disease rate are on the increase. The current regulations will eliminate for all practical purposes services for those currently without children or to teenagers, even though it is precisely with these groups where the cost-benefit ratio is most favorable in avoiding an unwanted pregnancy.

Q. 2. What in your estimate is the number of individuals receiving family planning services under the authorities of title IV-A?

A. 2. We do not have an estimate of the number of individuals currently receiving family planning services under the authority of Title IV-A. According to projections by the eight states prepared prior to publication of the revised regulations, in FY 1974 the states expect to collect about \$1.8 million through IV-A (5.8% of the projected total expenditure of \$31.3 million). Comparable projections for reimbursements under Title XIX (Medicaid) were \$1.9 million (6.0% of the total).

Q. 3. What do you estimate the impact of the new regulations will be on the numbers of individuals who will receive services?

A. 3. Six states in Region IV currently have Title IV-A contracts (Fla., Ga., Ky., N.C., S.C. and Tenn.). According to the old regulations, family planning officials in these states estimated that more than 1.3 million persons would be eligible for IV-A reimbursement. In conversations with these officials subsequent to publication of the revised regulations, only about 250,000 would be eligible for Title IV-A reimbursement, for a decline of about 80%. The decrease has been so drastic in a number of states that they are planning to drop existing Title IV-A contracts and instead use only Title XIX.

Q. 4. What administrative difficulties do you foresee in conforming with the requirements of these regulations?

A. 4. The administrative difficulties in conforming with the applicable regulations are considerable. For example, according to the new regulations a social service plan must be prepared and periodically updated for each person certified as eligible for Title IV-A reimbursement. Although the intent is commendable, at least as long as this does not become a device to invade excessively family privacy or interfere with personal decision making, it will impose an intolerable administrative burden on many under-staffed local social service agencies. At the family planning program level we are already encountering substantial difficulties in getting patients identified as eligible, getting them certified, in calculating the costs of each service rendered so that billing can be accurate, and in negotiating with some state welfare agencies a reimbursement cost that is sufficient to cover such program components as outreach, training, program administration and education. The tendency has been in some states to set very low reimbursement schedules which would cover only the direct costs of services but not these other program components which are vital to an effective and quality program.

Q. 5. Do you have any additional comments on the effect of these regulations on the ability of organized programs as well as private physicians to provide services under the authorities of title IV-A?

A. 5. No, except to note that we sense a growing pessimism and even cynicism among program administrators regarding the Administration's willingness to continue strong support for expansion of family planning programs. The comment is often made that by virtue of the restrictions imposed by the new Title IV-A

regulations, the government is undermining family planning program support with one hand while it tries to build it up with the other. Moreover, some states are concerned lest the multiple funding regulations and reimbursement levels may lead to patients becoming labeled "Title IV-A", "Title XIX", "Title V", etc., as they walk through the clinic door and are registered under one or another reimbursement category.

Q. 6. What is the total amount of funding available from non-governmental sources to support organized family planning services? How much of this can be used for social services matching funds?

A. 6. Current estimates place FY 1974 direct state appropriations for family planning at about \$1.2 million (3.8% of the total), with some five states making direct contributions. At least several other states are trying to get direct state support but this will probably not be forthcoming until next year's legislative session. The eight states will contribute in addition about \$2.5 million in matching funds (almost 8% of the total) and another \$1.4 million (4.5%) will be obtained from other sources, mainly OEO and other federal authorities. The projected FY 1974 total in non-federal funds will be just over 11%, of which perhaps \$1 million has not yet been matched for federal funds requiring matching, and which could be used to generate almost another \$9 million for Title X monies, if these were available. Title X funds are projected at the approximately \$20 million level (64% of the total) in FY 1974 and all federal funds will amount to almost 90%.

Q. 7. Do you have an estimate of the amount of funding available from the local and state governments?

A. 7. See question 6 above. In the few cases where studies have been done at the local level, the contribution of counties to family planning programs is substantial and has tended to be underestimated in the past.

Q. 8. What is the estimated cost of providing services to an individual?

A. 8. Various studies conducted nationally and in this region suggest an average annual cost of serving one patient to be about \$60. This figure tends to be higher in new programs, small programs, rural programs, and comprehensive programs with extensive outreach and informational services, and the range of costs varies between the middle \$30s and up to over \$100. The average cost seems to have declined or at least maintained steady over the past several years but we have reason to believe that further economies will not be possible except by sacrificing quality and comprehensiveness. Already, most programs involve only two patient contacts per year and only one of these is with a physician.

Q. 9. Have new programs been established in terms of accessibility to population groups which previously had limited access to services as a result of Title X programs?

A. 9. The answer is most emphatically "yes". Without Title X funds family planning in the Southeast would be at a far smaller scale than is the case today. Before Title X such funds as were available from state and Title V sources tended to be used on very passive programs which consisted of one or several clinics per month per county. Almost no effort was made to recruit new patients or to do active followup of those who failed to return on schedule, and the services were generally not comprehensive. Only with the availability of Title X funds has it been possible to mount active outreach programs and to direct recruitment efforts at high risk populations where the advent of an unplanned pregnancy can have devastating social and economic consequences.

Q. 10. What proportion of these programs provide for coordination with programs offering comprehensive child and maternal health services?

A. 10. At least nominally, most family planning programs in the Southeast are coordinated and indeed integrated with programs offering child and maternal health services. This is because most family planning clinics are held in the same location (usually the county health department) and by the same personnel as operate the maternal and child health program. However, in many cases available funding for the county health department is so limited that the MCH services are gross inadequate both as regards equality and coverage. Despite the inadequacy of family planning program funding,¹ the MCH program is in even worse condition and coverage is very restricted. It should be added that with few

¹ Total projected FY 1974 family planning expenditures from all sources are \$31+ million enough to care for 500,000+ active patients at \$60 per patient. About 1.8 million medically indigent women are estimated to be in need of subsidized family planning services by the end of FY 1975, a program coverage which would require expenditures in excess of \$100 million annually. The Region IV "Plan for Family Planning Services" of June, 1972 estimated total funding requirements for FY 1974 at \$97.062 million in contrast with the projected availability of \$31 million.

exceptions, there is a very poor link between hospital maternity wards and family planning programs. In other words, even though it is advantageous for a number of reasons to recruit women into the family planning program from the maternity service of a hospital, this has generally not been possible in the Southeast and reflects inadequate coordination between these two activities.

Q. 11. Are there still many areas where services are not easily available to those who want them? Do you have an estimate for new organized programs and the type of community needing them?

A. 11. The Region IV "Plan for Family Planning Services" of June, 1972 was based on the aggregation of the Region's 736 counties into 102 multi-county planning districts. Forty-three of these districts were designated of high priority and at the end of FY 1973 approximately 24 of these high priority districts will have been started, though virtually all lack sufficient funding to provide for significant program expansion in FY 1974. The remaining 19 priority districts cannot be adequately funded with projected resources and we are now in the very distressing and anomalous situation of having promoted interest in family planning program development at the district level but are not able to provide startup funding. Moreover, once the 43 highest priority districts have been funded, many of the almost 60 remaining districts will require additional program expansion and improvement. The burden of inadequate program development falls, as you might expect, primarily on the poor rural countries. For example, more than 30,000 of the 70+ thousand women now being served in Georgia reside in the Atlanta area, and hence the Georgia program is still predominantly an urban one. Future program development should preferentially take place in the depressed rural areas where available resources to undertake program development and operation are in shortest supply.

Senator CRANSTON. Our next witness is Dr. Louise B. Tyrer, fellow of the American College of Obstetricians and Gynecologists, and project director, Division of Family Planning, American College of Obstetricians and Gynecologists.

We appreciate your presence here.

STATEMENT OF LOUISE B. TYRER, M.D., FELLOW OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AND PROJECT DIRECTOR, DIVISION OF FAMILY PLANNING, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. TYRER. I am Dr. Louise B. Tyrer, FACOG, project director of the Family Planning Division of the American College of Obstetricians and Gynecologists. I have been a practicing obstetrician-gynecologist for 25 years in California and Nevada, serving as director of the maternal and infant care project in Reno, Nev. for 3 of those years.

I joined the American College of Obstetricians and Gynecologists 2½ years ago in Chicago to initiate and direct its newly created Division of Family Planning. The American College of Obstetricians and Gynecologists represents 15,000 qualified obstetrician-gynecologists throughout the country. The college has lately taken a fresh look at its long-range goals and immediate priorities. We are not happy with the United States' relative position among nations in respect to its infant mortality. We feel very strongly that within 10 years, the infant mortality rate in America can be cut in half, and the death of women from gynecologic and breast cancer can likewise be reduced by 50 percent. The college is dedicating itself to the attainment of these goals; they serve as a touchstone of effectiveness and priority for college programs. Family planning ranks high as a means by which these goals may be realized.

It has been shown that family planning is the most cost-effective method of insuring that babies are well born and well cared for, which

will reflect in statistics documenting reduced infant mortality and mental retardation. Already data are accumulating that show that perinatal mortality rates are dropping in certain large cities where extensive family planning services are being delivered.

Data are presented for the four largest cities which show that perinatal death rates have dropped from 20 to 8 percent in the past 10 years, which we feel is definitely related to the provision of family planning services.

We feel that by continued Federal support through legislation such as that currently introduced and under discussion the perinatal mortality rate, and maternal mortality rate will continue to decline on a national scale.

Undoubtedly the future will evolve a more effective delivery system for family planning services, but this requires time. It is our opinion that in order to adequately deliver family planning services at the present time in this country, the organizations and institutions presently involved in the delivery system must receive continued financial support through Federal funding. The American College of Obstetricians and Gynecologists is an example of such an organization.

In 1970, the college supported Public Law 91-572, which established the Office of Population Affairs in HEW, and authorized grants and contracts for family planning services, training and research. Although ACOG has always been involved in the setting of standards for the delivery of quality obstetric and gynecologic care for women, it was only with the initiation of a grant from the Office of Economic Opportunity to the ACOG in 1970 to establish research and demonstration projects in eight large medical institutions in various regions of the country, that ACOG developed within its organizational structure a division of family planning, which places special emphasis on this most important aspect of health care for women. The expanded emphasis on family planning as an important part of ambulatory gynecologic care has thus filtered through the ACOG organization. It has deeply committed and involved its 15,000 members in delivering family planning services. Current statistics reveal that 21 percent of family planning patients are receiving their services through private physicians.

The initial grant to the American College of Obstetricians and Gynecologists in the amount of 615,427 Federal dollars, with 20 percent matching funds contributed by the grantee was to develop research and demonstration family planning programs. Eight projects are now delivering family planning services under this grant. It has currently been refunded for program year C in the amount of 762,101 Federal dollars for 12 months from December 1, 1972, to November 30, 1973. This only represents funding in place, and does not provide for the rapidly expanding program growth our projects are experiencing.

The main impact of this program is to reach the postpregnant patient, whether she be postpartum or following abortion, and effectively involve her in family planning to assist her in regulating her fertility so that she may achieve her reproductive goals. The woman in the immediate postpregnant period of her life is the most receptive to initiation of family planning. Another goal of the program, which is a dividend of family planning, is to provide the woman with comprehensive health screening during the time that she is enrolled in the

program. Medical guidelines under which the programs operate have established criteria for such as:

- (1) A complete history and physical examination annually;
- (2) A battery of laboratory tests which included Pap smear, hematocrit for the detection of anemia, screening for venereal disease, urinalysis, and other medically indicated tests;
- (3) Patient education and counseling;
- (4) Contraceptive prescription;
- (5) Infertility services;
- (6) Referrals for continuing medical care when indicated; and
- (7) Consumer participation for improved patient care and community involvement.

The guidelines for the operation of the interconceptional care program have been approved by the advisory committee to the division of family planning of ACOG, and have been disseminated nationally not only to the fellowship of the college, but to family planning projects throughout the country, and are being utilized by these projects to upgrade the quality of their services. A copy of these guidelines is attached to this report. (See p. 748.)

The interconceptional care program, as we named our project to reflect our services, has delivered family planning to 18,847 new patients in the past 30 months. The cost per unduplicated patient for the delivery of this type of high-quality comprehensive family planning during Program Year B, September 1, 1971 through August 31, 1972, and serving 8,664 low-income women, was \$61.26 per patient.

A formula established by Fred Jaffe, director, Center for Family Planning Program Development, Planned Parenthood, New York, N.Y., determines the immediate cost effectiveness of Government expenditures for services, represented as a cost savings resulting from averted births. The factor 2.9—which includes costs of birth, 1-year infant care, public assistance and food stamps—when applied to our program year cost of \$930,821, reveals a savings of \$2,377,795 in 1 year to the Federal Government. We think this is a well-documented figure and it demonstrates very impressively the effectiveness of the program.

Through the ICC programs we have also developed training modules for family planning nurse practitioners, and are successfully utilizing these nurse practitioners to increase the critically short professional staff effectively delivering family planning services to patients. These programs are useful models as we at ACOG continue our work with professional personnel from the field of nursing in the development of nationally applicable standards for training in this new field.

This background material presented in regard to the ICC program pertains only to the utilitarian logic associated with the program. However, the rewards of the program are much greater to individuals and to society in preventing the birth of children who are not wanted, or who are born to a mother with development or health deficiencies, or to a family with insufficient resources to care for the child, and also in assisting those couples who need specialized services to achieve a desired conception.

The Division of Family Planning of the American College of Obstetricians and Gynecologists is also involved in another activity which can best be carried out through a large organization such as

ours. Through a contract sponsored by the National Center for Family Planning Services, in the amount of \$283,687, the Department of Physician Education in Family Planning of ACOG has developed training programs for physicians. These programs have been developed in five medical institutions in varying regions of the country to train physicians in several categories in the delivery of family planning services. The training programs are directed toward the following categories:

- (a) The undergraduate medical student.
- (b) Interns and resident physicians in specialties other than obstetrics and gynecology.
- (c) The resident physician in obstetrics and gynecology.
- (d) Physicians in family planning programs and the graduate general practice physician.
- (e) University and college health service physicians.

In the first year of the contract, which will end May 30, 1973, we will have provided specialized training in the delivery of family planning medical services to over 500 physicians. These physicians then return to their practice with knowledge of the most recent developments in the field of family planning, updated clinical skills, and imbued with enthusiasm to deliver family planning services in various settings. Many physicians deliver services to those who cannot otherwise afford care through federally funded clinics. Some physicians have subsequently offered family planning services for the first time in their private practice. We have been involved with the development of curricula and training in family planning for medical students, interns, and resident physicians, both in and outside of the field of obstetrics and gynecology.

These training programs have been very successful in accomplishing their objectives and are continually oversubscribed. At the present time, there is no other mechanism for continued support and funding for these projects, except through the federally funded mechanisms. This is an effective means for developing a resource pool which will relieve the critical physician shortage in the family planning field. The resources of professional and educational institutions can be tapped to provide effective leadership—not only in education, training, and research, but also in the actual development of service delivery models.

As a practicing obstetrician for the last 25 years, it has been apparent to me that the ideal contraceptive agent has not been found. There are problems with all contraceptive agents presently available. Further research is necessary in this most important field. There must be continued research in the field of human reproduction to fill in the gaps of our fundamental knowledge in regard to this field before a strictly goal-oriented program to develop ideal contraceptives stands a chance of success. There is a need for continued research in two areas: basic research in regard to reproduction and applied research in regard to the development of an ideal contraceptive agent. Although some private agencies, foundations, and commercial firms are conducting some scientific research in this field, their funding level has been markedly reduced. Growth in research in the field of reproduction and population will have to come from additional commitments of the Federal Government.

Effective family planning is a continuing, ongoing service which cannot be delivered once over a short period of time. The reproductive period of a woman's life is beginning earlier all the time, and presently may start as young as age 10 or 11, and may continue to age 50. Termination of family planning services anytime during the reproductive phase of a woman's life can negate all the service she has received to date. Effective family planning must be a continuing service to each individual and terminated only by the recipient's desire to discontinue, when her need no longer exists.

We understand that the administration has testified that title IV-A, and, in particular, title XIX, will supply an adequate means for growth for family planning services in the future. This may be so, but it may also be a false hope. If, on the other hand, proper care is taken in writing flexible, supportive regulations so that eligibility for service is not curtailed, and if States will assume their rightful responsibilities, then it is possible that this program can reach its goal as stated by President Nixon in 1969.

The American College of Obstetricians and Gynecologists, because of its goals and dedication to preserving the lives and health of women and their offspring, will keep close watch on the development of this program to make certain that quality family planning services continue to be made available to disadvantaged women who cannot otherwise obtain such services. If it appears to us that program goals are not being met, our voice will be heard. If the availability of service in family planning is limited through lack of project grant support and through restrictive eligibility criteria, this will exclude many women who need and want family planning services from obtaining them. This will then result in a rise in unwanted, unplanned, and high-risk pregnancies. Such pregnancies most frequently terminate with an unfavorable outcome. The outcome often results in precipitating the patient who has previously been marginally independent into welfare rolls for continuing care for herself and her offspring.

It may also turn the patient toward what she considers her only other option—an abortion. As obstetricians and gynecologists, we are dedicated to preserving the life and health of women under our care. As evidence of our dedication to improve health care for women, the American College of Obstetricians and Gynecologists did in May 1968, adopt the policy that abortions may be performed to preserve the health of the mother. The election of abortion by a patient and her physician is far from the ideal and indicates a failure for the patient in the regulation of her reproductive functions.

There remains no doubt in our minds that the delivery of adequate family planning services can and does create a meaningful reduction in the number of women who turn to abortion as their alternative to lack of contraception. Continued support and expansion of family planning programs will greatly reduce the number of women bearing and caring for an unwanted child under poverty conditions, and at the same time, substantially reduce the number of women who turn to abortion as their only alternative.

The experience of the college, and substantiated by the division of family planning both as project grant administrators and collectively as physicians serving patients, has been that family planning

- (1) Can effectively reduce infant mortality and morbidity;
- (2) Can measurably improve the health status of women;

(3) Is a cost-effective method of achieving these ends; and

(4) Can reach the patient population most at risk by providing federally funded programs with reduced socioeconomic barriers and a minimum of disincentives. A woman who delays or is delayed in seeking service, or whose benefits are interrupted, is not simply deprived of the service for that period of time. The result instead is likely to be an unwanted pregnancy, an unhealthy child because life circumstances were unfavorable to pregnancy and birth at that time, and a temporary or permanent interruption of education or wage earning which may doom the family to poverty or welfare status for years to come.

I, therefore, on behalf of the American College of Obstetricians and Gynecologists, wish to endorse the proposed amendment to title X of the Public Health Service Act to extend appropriations authorizations for 3 fiscal years so that American women in need may be served.

Thank you.

Senator CRANSTON. Thank you very, very much for a very detailed and useful statement.

You describe two excellent programs administered through the American College of Obstetricians and Gynecologists currently supported by Federal project grants, one from OEO and the other from the National Center for Family Planning Services. The administration has proposed the termination of OEO. I am glad to see you have received funding for support of the special demonstration program from OEO through 1974, but when 1975 comes, will this program again be seeking renewal funding?

Dr. TYRER. That is something I cannot answer at the present time. Indications are that all the OEO programs will be transferred to HEW. At the present time a determination has not been made in regard to our program.

Senator CRANSTON. You expect to be seeking further funding?

Dr. TYRER. Yes, we do.

Senator CRANSTON. Where will you go for that support?

Dr. TYRER. If OEO is phased out, we intend to apply for continued funding through HEW. We would like to keep the grant intact as far as involvement with the college. We are involved with very important research projects through the program, which if we were not funded to continue, the research would suddenly be terminated and could not be carried on.

Senator CRANSTON. There seems to be some reason to believe, without being definitive, that the administration intends to phase out all grants, so if that program is followed without change it would effect all projects.

Dr. TYRER. We see this as a serious problem.

Senator CRANSTON. It is my understanding that one of the great values of the two projects is that they are repeated in different regions of the country so that their effectiveness can be measured under varying circumstances. Without the national direction provided by your organization and by a specific Federal agency with supervisory responsibility, could these programs achieve their goals and contribute to the field of knowledge in providing services?

Dr. TYRER. No, they could not.

Senator CRANSTON. S. 1708 adds new requirements which provide assurance that individuals participating in research projects shall do

so only with full and informed consent. The bill also provides that drugs may be provided only for those uses approved by the Food and Drug Administration except where deemed medically essential in accordance with regulations. Do you see any difficulty in providing services under these conditions?

Dr. TYRER. No, I do not.

Senator CRANSTON. I thank you very much, your testimony has been very valuable.

Thank you a great deal.

Dr. TYRER. Thank you.

Senator CRANSTON. Our next witness is Mrs. Grace Olivarez, director, Institute for Social Research Development, University of New Mexico, and member of the executive committee, Citizens Committee on Population and the American Future.

I am delighted to see you with us. It is a pleasure to have the opportunity to be with you once again. I appreciate your coming all the way here to the hearings.

STATEMENT OF GRACE OLIVAREZ, DIRECTOR, INSTITUTE FOR SOCIAL RESEARCH DEVELOPMENT, UNIVERSITY OF NEW MEXICO, AND MEMBER OF THE EXECUTIVE COMMITTEE, CITIZENS COMMITTEE ON POPULATION AND THE AMERICAN FUTURE

Mrs. OLIVAREZ. I am Grace Olivarez, member of the executive committee of the Citizens' Committee on Population and the American Future. From 1970 to 1972, I served as vice chairman of the National Commission on Population Growth and the American Future. The Commission was established by Congress to conduct a 2-year study of the probable course and consequences of population growth in the United States. The citizens' committee was created to foster discussion of the Commission's findings and recommendations.

The Commission completed its research and reported to the Congress, the President and the Nation in March 1972. It was our conclusion, based on 2 years of study, that no benefits will accrue to our country from population growth beyond that to which we are already committed by past births. In fact, the Commission found that slowing growth could provide the opportunity to cope with a number of pressing social problems that confront our society. As a result of our study, the Commission made a number of recommendations. Some of these relate very specifically to the legislation before this committee today.

Mr. Chairman, I believe it is important to point out first of all that as a member of a minority group and as a woman, I would have rejected the Commission's recommendations had they been solely directed at stabilizing population size. Other members of the Commission would surely have joined me. I believe the key to the Commission's thinking was the hope of encouraging actions that would improve the quality of life in our country. I believe the operative language in the Commission report is the following:

We wish to develop recommendations worthwhile in themselves, which, at the same time, speak to population issues. These recommendations are consistent with American ethical values in that they aim to enhance individual freedom while simultaneously promoting the common good—our policy recommendations embody goals either intrinsically desirable or worthwhile for reasons other than demographic objectives.

No recommendation in the Commission report is more reflective of this than that which states:

All Americans should be enabled to avoid unwanted births. Major efforts should be made to enlarge and improve the opportunity for individuals to control their own fertility, aiming toward the development of a basic ethical principle that only wanted children are brought into the world.

Mr. Chairman, the Commission was informed that, in the 5-year period from 1966 to 1970, 44 percent of all births to currently married women were unplanned; 15 percent were reported as having never been wanted. As shocking and distressing as these figures are, they are low estimates. They include only births to married individuals. In the 3 years from 1965 to 1968, there were 1.2 million births out of wedlock. Surely an even higher percentage of these were unplanned and unwanted. It would seem from these statistics that the reduction of unwanted and unplanned pregnancies would have impressive demographic effects.

However, our justification for a national policy and program to reduce unplanned and unwanted pregnancies is independent of its demographic significance. These pregnancies represent personal, health, social, and economic problems of serious proportions. For the woman affected, an unplanned pregnancy and birth at least indicates a lack of control over her immediate destiny. It may mean personal tragedy. The health problems associated with unplanned and unwanted pregnancies are serious. These pregnancies are more likely to result in babies born prematurely and, therefore, threatened by low birth weight and birth defects. Higher numbers of infant and maternal deaths are reported in unplanned and unwanted pregnancies.

The personal and economic consequences are chilling. For the school age girl, an unplanned pregnancy all too often means dropping out of school and cutting off future opportunities for education, a good job and personal fulfillment. For the low-income family, such an occurrence may result in economic dependence. Many couples learn to cope with the consequences of unplanned pregnancy, Mr. Chairman, but it can hardly be said that they contribute to the quality of life for parents or children.

The Commission believed the way to prevent unplanned pregnancies is through provision of family planning information and services and through the development of improved methods of contraception. Middle-class women have generally had access to contraceptive information and services through their private physicians. Low-income women have, until recently, generally not had access to these services. The result has been that the rate of unwanted and unplanned pregnancies among low-income women has been much higher than among middle-class women. Studies have indicated that there are some 6.6 million low-income American women who want and need family planning services but will not have access to them except through subsidized programs.

The effort to provide these family planning services through federally subsidized programs began to build in 1967 and was given great impetus by passage of the Family Planning Services and Population Research Act in 1970, which became title X of the Public Health Service Act. That act now provides the bulk of funding for these services. The presumption, in passage of the title X family planning

services program, was that there are large numbers of women who want family planning services and will use them if they are provided in a convenient and dignified manner. This presumption has proved valid. By June 30, 1972, over 2.6 million women were using family planning services provided through federally subsidized programs. Studies indicate that, if Federal support continues to grow at a reasonable rate, all of the women in need of this health service can be reached by 1976.

Reaching all of the women in need is a goal stated both by President Nixon in 1969 in his message to Congress on population and by the Commission in its report. The Commission urged that the Federal program "be expanded, strengthened and provided with the resources necessary to complete its mission." Specifically, the Commission recommended that Congress pass new legislation "extending the current family planning project grant program for 5 years beyond fiscal year 1973 and providing additional authorizations to reach a Federal funding level of \$225 million in fiscal year 1973, \$275 million in fiscal year 1974, \$325 million in fiscal year 1975, and \$400 million thereafter."

The totals recommended by the Commission are based on the 5-year plan for family planning services and population research prepared by the Department of Health, Education, and Welfare and published in 1971 which projected funding requirements for service delivery ranging from a minimum of \$250 million in fiscal year 1973 to a maximum of \$434 million in fiscal year 1975. Testimony before this committee last year indicated that only about \$50 million of that total could be expected to be forthcoming from State and local governments and private sources.

In contrast to the Commission's recommendations, S. 1708 calls for only a 3-year extension providing \$159 million in fiscal year 1974, \$207.5 million in fiscal year 1975 and \$225.5 million in fiscal year 1976.

It is true that, due to the President's veto of the fiscal year 1973 appropriations legislation for the Department of Health, Education, and Welfare, the family planning program has stood still for an entire year. Twelve months of progress has been lost. It is fair, I believe, to argue that as a result of that, it is logical to adjust authorizations for fiscal year 1974 and onward to reflect the lack of increment in the family planning program in the last year. However, even considering such an adjustment, the levels of funding in S. 1708 are below those suggested as necessary by the Department of Health, Education, and Welfare and recommended by the Commission. Further, it is unfortunate that S. 1708 does not propose a longer-term commitment to the family planning program than 3 years. I believe that this longer term commitment would be most helpful in enabling service facilities to do the kind of long-range planning that would enhance health service delivery systems.

Mr. Chairman, there are other provisions of S. 1708 that are very much in consonance with the Commission's report and with which I am particularly pleased. I have always been uncomfortable with the fact that present law gives "priority to low-income persons" for receipt of family planning services. That language smacks of "Stop those welfare women from overbreeding." It is an unjustified charge and has frightening overtones. It became especially suspicious last year when HEW actually sought to impose a means test for receipt of services. The Commission took specific exception to that action and I am glad

to see such tests prohibited by S. 1708. Location of these services in places convenient to those in need of services is consistent with the Commission's view.

Low-income women need family planning services but heaven knows, we need all kinds of health care. Government concern about the health of poor women is suspicious when it begins and ends with "birth control." The Commission proposed that all fertility-related health services—from family planning to pediatric care—be fully financed. The provision of section 1006 requiring that family planning projects make arrangements for a comprehensive range of child and maternal health services, including infertility services to be available to family planning clients, is an important step in the right direction. It is grossly inadequate, but at least it is a beginning.

Mr. Chairman, the other essential ingredient of a program to reduce unplanned fertility is a greatly increased program of research. I am sure you recall that the Commission reserved the strongest language in our report for the recommendation concerning fertility-related research. We stated:

The Commission recommends that this nation give the highest priority to research in reproductive biology and to the search for improved methods by which individuals can control their own fertility.

This is not a program that affects the lives of small numbers of people. There are some 84 million Americans in their reproductive years. None of them, no matter what their income or status, has access to a perfect contraceptive.

Contraceptive technology is amazingly primitive. In this technologically advanced age, prevention of an unwanted birth, requires effort, money, inconvenience, occasionally pain, and, far too often, resort to abortion. There is no contraceptive that is 100 percent safe, effective, acceptable, reversible, and inexpensive that is available without prescription.

Although recent advances in contraceptive technology have been impressive, they have not lived up to initial expectations. While oral contraceptives are the most popular method of contraception in this country, they are far from perfect and more and more women are abandoning their use. The problems are numerous. Oral contraceptives require daily application. They are expensive. They require medical monitoring. Most important, though, are the uncomfortable and sometimes dangerous side effects associated with their use.

Estrogen in oral contraceptives is known to increase the coagulatory action of blood. The possibilities of blood clots and, therefore, of thrombophlebitis, stroke, heart attack and pulmonary embolism are increased. Unpleasant side effects, including weight gain, changes in skin pigmentation, sore breasts and unexpected bleeding are common. Women with histories of liver disease, cancer of the breast and other medical problems are cautioned not to use these drugs or to use them only under the closest supervision. For all of these reasons, between 36 and 58 percent of women who begin using the oral contraceptives discontinue use within 18 months. Millions of others continue to suffer irritating side effects in the quest to be safe from unplanned pregnancy.

The long-range effects of the oral contraceptives are not known. Yet 8 million American women take this powerful drug each day.

The intrauterine device was thought to be the perfect contraceptive when it was first introduced. It was cheap and didn't require continu-

ing application. Results have been disappointing. Women who have not had children usually cannot use this method. Many others expel the device, sometimes without knowing it. Others continue to have unusually long and heavy menstrual periods. After 18 months of use, a total of 20 to 35 percent of users abandon the IUD.

The drawbacks associated with use of the older methods of conception, such as the condom, diaphragm and foam, and rhythm, are well known. The first three require application immediately before intercourse. Rhythm requires periodic abstinence. Effectiveness, either because of failure of the method or failure to use it, is limited. When both reasons are considered, the failure rates run as follows—condom 16 percent; diaphragm 18 percent; rhythm 28 percent; foam 29 percent.

Sterilization requires a surgical procedure and is really suitable only for those individuals who are certain they have completed their childbearing.

Then, of course, Mr. Chairman, there is abortion. It is estimated that about 1.3 women each year attempt to avoid unwanted births by resorting to abortion. As you know, I strenuously oppose abortion. I find it morally and ethically unacceptable. I dissented, as you did, from the Population Commission's position on abortion. Let me point out, however, that even those members of the Commission who favored liberalization of abortion laws, stated their aversion to this procedure as a method of family planning.

Mr. Chairman, in January the U.S. Supreme Court acted to wipe most abortion laws off the books. I disagree with that ruling. Since January, efforts have been mounted to amend the Constitution to overturn the Court's ruling. I oppose those efforts.

I propose that we act to attack abortion. Let us act to make it an anachronism. You are opposed to abortion. I presume numerous Members of Congress are opposed to abortion. The President says that he is opposed to abortion. If you are, you can do something about it. Don't amend the Constitution. Laws against abortion have never stopped them from occurring. A constitutional amendment won't stop them from occurring. The Congress can demonstrate the sincerity of opposition to abortion by investing more effort and more money in contraceptive research. Improved contraceptive technology, improved availability of information and family planning services are the best means to reduce demand for abortion.

Mr. Chairman, experts have stated that, if we continue research at the present rate, it will likely be another 5 to 10 years before there is another substantial breakthrough in contraceptive development. I find that time lag and its consequences unacceptable. I presume that you do too. The Commission, acting on the basis of recommendations from panels of experts, urged that the funding for fertility-related research be increased to \$150 million by fiscal year 1975. I regret that S. 1708 proposes only a little over half of that amount for all population research by fiscal year 1976.

Finally, Mr. Chairman, I would like to comment on the organizational and administrative proposals of S. 1708. The Commission on Population Growth and the American Future concluded that existing organizational and administrative structures of the Federal Government were not adequate to the task of carrying out many of the

recommendations made by the Commission and, therefore, suggested several changes.

The Commission felt that the Office of the Deputy Assistant Secretary for Population Affairs in the Department of Health, Education and Welfare needed strengthening, especially in terms of staff support, in order to give the necessary direction and coordination to Department programs in this field. In addition, the Commission recommended the creation of a separate Institute for Population Sciences within the National Institutes of Health. The purpose of this was to provide a stronger base of support for an expanded and more focused population research effort, to facilitate acquisition of qualified personnel, laboratory and clinical space, to increase the visibility of the program and to aid in commanding the level of funding recommended by the Commission.

S. 1708 recommends the establishment of an Assistant Secretary for Family Planning and Population Science and the creation of an Office of Family Planning and Population Science to be located within the Office of the Secretary of HEW. This assistant secretary is to be appointed by the President with Senate consent. Provision is made in the law for full-time professional and clerical staff and a reasonable level of funding is provided for that staff. In addition, S. 1708 would establish within this office a National Center for Family Planning and a National Center for Population Science.

It appears to me, Mr. Chairman, that the powers and responsibilities assigned to the Assistant Secretary, the Office of Family Planning and Population Science and the two Centers, especially in the development and administration of budgets for the relevant programs, are quite adequate to the accomplishment of the goals the Commission stated as necessary for improving the population related programs of the Department of Health, Education and Welfare.

Thank you very much for the invitation and the opportunity to address you. I apologize for the length of my testimony, Senator. I am a firm believer that the mind will absorb only as much as the seat can withstand, so I will stop now.

Senator CRANSTON. Thank you very, very much. Dr. Simmons of HEW referred yesterday to the provisions of S. 1708 as unnecessary and duplicative and suggested that it is more appropriate to fund population research under the general research authority of title IV of the Public Health Service Act. Would you care to comment on that proposal?

Mrs. OLIVAREZ. If cancer research and heart research and all other medical research was also launched under title IV, I would take my chances with family planning research being bunched up under title IV. I am opposed to that action because it appears to reduce our commitment to population research. I find it incongruous that on the one hand the administration claims to oppose abortion, but on the other hand it eliminates funding that would make abortion totally unnecessary. I think this proposal of the Administration combined with a freeze on research funds certainly gives the unfortunate impression that the goal of improved contraceptive technology is being phased out at a time when we feel it is more necessary than ever, given the failure of other methods.

Senator CRANSTON. The Commission on Population Growth and the American Future suggested that certain benefits would accrue to our

society if population size eventually stabilized. The birth rate has now reached a level that if continued over a period of time would eventually result in stabilization. Does this in your opinion effect the need for an increased commitment to family planning services and population research?

Mrs. OLIVAREZ. Well, if you recall, Senator, during the Commission deliberations some people where of the impression that we no longer needed to worry about population stabilization, that we were reaching that level, and somebody very aptly pointed out, I believe Dr. Duncan pointed out, that we felt the same way in the 1930's when there seemed to be stabilized population, and then we got the baby boom. No. 1, I do not think we can depend that blindly on the fact that we seem to have reached a so-called stabilization population. I find it very painful and uncomfortable to talk in terms of numbers, because I deal with individuals on a daily basis, and I think the need of individuals to be able to choose whether and when to have children and the ability to do so free of societal pressures, and with physical safety and comfort is independent of the birth rate. One of the things the Commission specified constantly is that we should not think only in terms of demographic effect, but we should think about individuals, because the thrust of the report was that we were interested in quality of life.

I read recently that there are in the country right now 1 million women at the age of 39 and 2.1 million women of the age of 13, that are just arriving at child-bearing age. If we slow down or slacken our efforts in making available more adequate contraceptives and family planning services programs, the so-called stabilization we have experienced in the last 2 years is going to fall through the floor.

Senator CRANSTON. Last year we heard very constructive testimony from representatives of both black and Chicano communities who voiced a concern that family planning services should be offered only in conjunction with a full array of other social and health services which had higher priority to members of these communities. I have tried to address this concern in S. 1708 by requiring consumer participation in the decisionmaking process of organized programs, and by requiring that organized programs provide for coordination of family planning services with the provision of comprehensive health services. If organized programs are not expanded, do you see how these objectives can be built into alternative approaches of providing the services as suggested by the administration, such as through medicaid and title IV-A of the Social Security Act?

Mrs. OLIVAREZ. No sir, again I feel very awkward about family planning being tied to title IV. In terms of medicaid, I do not know if you are aware that Arizona, which is my home State, is the only one of the 50 States that does not have medicaid. So, in that State alone, it just would not work.

Second, I just do not see that that proposal is going to reach the people that I am concerned with, to tie it in like that with title IV is totally out of the question. I prefer the provisions in your bill.

Senator CRANSTON. Do you believe the new regulations governing eligibility and periodic redetermination of eligibility for social services, including family planning services, will result in a measurable reduction in the number of individuals seeking family planning services?

Mrs. OLIVAREZ. It depends on how those eligibility requirements are applied. I am opposed to eligibility requirements because it differentiates totally.

Senator CRANSTON. Are there special concerns that the Chicano population has regarding family planning programs and do you feel that this bill adequately comes to grips with this concern?

Mrs. OLIVAREZ. I think it does come to grips. There are special concerns. One of the major concerns is that it took a while to sell Chicanos on family planning services, and then when we got to the level where we were getting everybody to accept the services, they turn around and tell us that they are cutting back on them.

We have not reached half the Chicanos that would like—I have never met a Mexican woman who did not want family planning services, but I have met a lot of them who were not getting them because they were not available. What is frustrating is to sell them on the fact that their problems are solved, that we now have family planning services, and just when we finish doing synthesizing, we have to turn around and tell them, I am sorry, we are not going to have the program.

I dare not go back and face them.

Senator CRANSTON. I am very grateful to you for your very constructive testimony and for your strong support for the bill.

Mrs. OLIVAREZ. Thank you so much.

Senator CRANSTON. Is Mrs. Shirley Okrent in the hearing room?

If not, our next witness is Judy Senderowitz, president, Zero Population Growth.

STATEMENT OF JUDITH SENDEROWITZ, PRESIDENT, ZERO POPULATION GROWTH, INC.

Ms. SENDEROWITZ. Mr. Chairman, I am Judith Senderowitz, president of Zero Population Growth. ZPG is a nationwide organization, with 20,000 members working toward the stabilization of population in the United States.

Based on our past appearances before this committee, you may already have anticipated that we strongly support and endorse S. 1708, the legislation before us. In our judgment this legislation represents a crucial public commitment to enable the American people to carry out the very exciting trend they have established in the past few years toward smaller families and an eventual stabilization of population. Specifically, we would like to focus our remarks today to the research and education sections of this bill.

Present contraceptive technology, though it provides a diversity and sophistication unknown one or two generations ago, remains exceedingly inadequate. The most effective methods, the pills and the IUD, are also those most likely to be contraindicated for reasons of health or reproductive history. They also require a greater amount of professional services. Those that can be most easily utilized and attained—the diaphragm, condoms, foams, and jellies—are less effective and rejected by many because of aesthetic considerations. Non-reversible methods have undergone greater improvements, and an increasing number of Americans have chosen sterilizations, but this method is obviously unsuitable for individuals delaying or spacing pregnancies.

Given these drawbacks and the difficulties often involved in attaining services, a high motivation level is required. The eagerness with which contraceptive counseling is accepted following a birth or an abortion attest to the need for making better contraceptives more easily available to begin with. Although abortion can now legally be used as a backup measure for contraceptive failure—or nonuse—everyone would agree that it is preferable to prevent an unwanted birth before conception. As a board member and director of volunteers at one of the first abortion facilities in New York City, I saw that for too many women their visit to the clinic was their first exposure to birth control. Most of them chose the most effective types in order to prevent a repeat abortion, but unfortunately they left New York City to return to areas less conducive to their continued need for medical monitoring.

New methods and improvements in existing ones, along with better information about them readily available to the patient, will allow for a real choice. At the present time, for example, more men would like to share in the responsibility of preventing undesired conception, yet there is very little choice for them.

Most studies have called for greater expenditures for contraceptive research than are presently being proposed by the current Administration budget. This funding level reflects a steady loss in momentum. The failure to keep pace can, in part, be accounted for by the administrative structure which requires population research to compete with the other components within the National Institute of Child Health and Human Development. Because of the multiple concerns that must be attended and directed, the Center for Population Research lacks focus and part of its program, behavioral research, suffers from its location in the highly medical atmosphere of NIH.

We have witnessed a welcome drop in the birth rate in the last few years, yet the predictions called for a rise as the postwar baby boom reached its peak child bearing years. Why the reversal? Some answers are commonly suggested: the depressed economy, changes in women's roles and working status, concern for population and environmental issues. But are we learning enough about these motivations to more accurately predict birth trends in the future? Planning to accommodate new Americans would obviously be improved by having a better sense of how soon and how many to expect, just as it's easier to design a plane when the number of passengers is known. A simple example is with school construction and teacher training. In some parts of the country now, lower grades have excess classrooms as the older children crowd into the upper schools.

Some of these changes in fertility behavior have immense implications beyond their demographic ones. Young women expect to have an average of one child fewer than their counterparts of fifteen years earlier. Census Bureau statistics show young women remaining single longer. What changes can we expect from such developments in industry, recreational and cultural activities, housing patterns?

Much research is needed to further delineate determinants of fertility behavior and the effects that behavior will have collectively in social structures. One of the most spectacular turnabouts in recent history has been the lowering of the birth rate in particular and the confrontation of other aspects of growth in general. In a society long

based on the "growth is good" ethic, certain segments are questioning uncontrolled growth—in their families, in their local communities, in the country, and in the world—and are opting for quality instead of quantity. The Commission on Population Growth and the American Future came to the conclusion that "no substantial benefits would result from continued growth of the nation's population." But I wonder if the public is adequately prepared to accept this trend as beneficial. In view of our history, a backlash could easily occur if society equates a slowing down process with lack of vigor in the absence of data which would show that fewer can be better.

A separate Center for Population Science, outside NIH, as provided by the proposed S. 1708 and the funding levels suggested in the bill would allow this pervasive issue to assume the dimension it requires.

Population education programs are practically non-existent. Although the rate and degree of growth affects nearly every aspect of life, most Americans are woefully uninformed. Six out of ten cannot cite or guess the population of the United States. At a session held not too long ago for incoming freshmen at a major NYC university, the students were told by a top city environmental official that the population of the United States was decreasing. The statistics that must be used in teaching population growth are no doubt confusing, but a dose of ingenuity can be used to translate them into meaningful terms. Yet textbooks and teachers ignore the subject. I was asked recently to locate a class being instructed in population issues where a national Japanese broadcasting company could film a scene for their documentary depicting America's concern with the issue. None existed as such; the closest I could find, after two days searching, was an urban ecology class that agreed to talk about population before the cameras. This in the nation's largest city. Your original education amendment to the Family Planning Services and Population Research bill was seen as a first step to develop programs in the field of population education and although provision was made for a grant and contracts program, the Office of Population Affairs never had one because of the low authorizations. Higher funding levels could possibly give realization to this program though some, including the Commission, have called for a separate Population Education Act. In any case, there is a need for better coordination of population education activities which this bill would allow.

Family planning in this country has a long way to go to deserve its name when 44 percent of births are unplanned, according to the latest national fertility study. Fortunately, most of these become wanted, although 15 percent of all births that are not produce unfortunate stress for the parents, child and indeed for society. Historically, children happened to people and were accepted as inevitable consequences of sexual behavior. This need no longer be true. The whole idea of questioning child-bearing may be new, but it is the most important planning for the future that individuals can make. Timing of the first birth is particularly critical, as it is a major determinant of expected economic situation and future births. An increasing number of people are questioning whether to bear children at all, whereas this option was previously socially suspicious. The one-child family, too has been shrouded in mythology and needs additional study.

Americans now desire smaller families. According to the research prepared by the Commission on Population, the resultant slowing and stabilizing of U.S. population growth will create many opportunities to improve the quality of life. But 3 million women still cannot hope to achieve their goals in desired family size. Many others cannot find adequate services or devices. Most do not understand the consequences of family size to their personal, social or physical environment. All three parts of the proposed legislation—services, research and education—will finally allow the American people to make informed choices about their future.

We would like to address ourselves briefly to the presentation yesterday by the Department of Health, Education, and Welfare. Regretfully, we are forced to the conclusion that the position taken vis a vis S. 1708 is not even a good faith one. The very funding mechanisms now proposed by the administration to replace the title X structure are those which in their rulemaking and administration they have done so much to hamper in the past 3 years. Their lack of concern for the population dynamics component of the research program is reflected in their casual assumption that the cross-fertilization which benefits biomedical research at NIH is also benefitting social science research. That NIH cannot be trusted to give appropriate priority to this program is demonstrated in the excellent material submitted for the record by Dr. Kantnor. And in its presentation the administration totally ignores the clear legislative intent of the Cranston amendment to encourage information programs in the field of population dynamics. To them, that part of the original legislation just doesn't exist.

It is the history of Federal programs in the family planning and population area that the Congress has had to take the lead at each step, and coerce successive administrations into following that lead. It appears that 1973 will be no different, and we urge upon you that you not let the administration position deter you from developing the strongest, most effective piece of legislation possible.

Thank you for the opportunity to testify.

Senator CRANSTON. Thank you very, very much. Your organization has been heavily involved, of course, in trying to educate the American people to your view of the population issue. I assume you would agree that this type of advocacy was the role of the Federal Government and population education generally. Do you feel there is an appropriate role in population education for the Federal Government now?

Ms. SENDEROWITZ. Zero Population Growth does have a definite position on this whole range of issues. We have been presenting that position to the American public. The Federal Government's position of course would be much different. We were fairly successful I believe in sparking the interest on the issue of population, which was virtually undiscussed a few years ago. But now we need more concrete research, more solid objective facts to be presented to the people.

I admit that some of our information is simplified and presents a definite point of view. I think the Government needs to make up for our lack of basic concrete research.

Senator CRANSTON. Could you comment on the adequacy of the coordination now existing between the various Federal agencies involved in population education?

Ms. SENDEROWITZ. First of all, very few agencies are doing anything about population education. But certainly coordination could be better

than it is. For example, in the Environmental Education Act, there is no official role granted to the deputy assistant secretary in the grant review and approval process, and we are not even sure how much is being done on population education.

The Office of Education says that \$11 million was spent in fiscal year 1971 on environmental and population education, and yet there is no documentation on just how much was spent on the population component.

Senator CRANSTON. Do you feel that the provisions in S. 1708, which would place the new Assistant Secretary for Family Planning and Population Science on the Environmental Education Advisory Council, and give him sign-off authority on population education projects would somehow help the situation?

Ms. SENDEROWITZ. Yes, very definitely. In this case at least there would be authority in the review process, and there would be some official authority input into what sorts of grants are being considered.

Senator CRANSTON. How do you feel about the funding level provided for the education section of S. 1708?

Ms. SENDEROWITZ. Certainly there need to be increased funding levels, as S. 1708 calls for. The grants program of the present act has gone unfunded because it was thought that the funding authorization was too low. And if the Environmental Education Act goes unfunded, we will certainly need higher levels of funding in S. 1708.

Senator CRANSTON. How do you feel generally about relying on welfare programs, medicaid, et cetera?

Ms. SENDEROWITZ. Well it does not seem to be providing services to as great a number of people that need those services and the complications in qualifying and so forth seem to complicate the issue and deter people from taking advantage of it.

Senator CRANSTON. The administration has insisted that authorization figures are not too low, but too high. We have had witnesses before the committee with evidence that the amounts we have authorized for family planning services and biological research are in their opinion justified. Could you comment on the authorizations we have provided in the research area in terms of need for social science research which you mentioned?

Ms. SENDEROWITZ. Well although it is not broken down according to the social science component, it seems that social science research is suffering and a larger budget is needed for the whole research program in order for the social science component to have a larger share. We cannot rob the biomedical part in order to give it to the social science part. We really need both. In the statement submitted by Dr. Kantnor it shows for fiscal year 1973 that although 116 projects were approved in this area, only 38 were funded. It seems that better projects are coming in and fewer are being funded with a lower dollar figure, as well, compared to fiscal 1972.

Senator CRANSTON. The administration also insisted that the research program in population dynamics would suffer from being removed from the National Institutes of Health. Could you comment on that point?

Ms. SENDEROWITZ. While it is not clear why the research program concerned with population dynamics would suffer, I am not sure that the administration made that clear, it seems that to remove the social science component outside of NIH, outside of the allied medical

atmosphere, could only improve the social science type of research that needs to be done. I think social science research within NIH is not getting its appropriate attention and encouragement.

Senator CRANSTON. Are you concerned about the point that I mentioned in my opening statement this morning about the possible development of the feeling that the administration looks upon these programs as a way to reduce the impoverished minority and welfare population in our country?

Ms. SENDEROWITZ. Could you repeat that.

Senator CRANSTON. Are you concerned with the point that I mentioned this morning—I do not know if you were here—I indicated concern that based upon the approach announced by the administration, a feeling might develop in the minority and poverty groups that family planning programs were to be turned into a program simply to reduce the impoverished and minority population in our country.

Ms. SENDEROWITZ. This is an issue that my organization has been confronted with too, that family planning is really a means to cut down on certain births, not all births.

The central fact is that middle class and upper class women have always gotten the medical attention they needed through private physicians, and what we would hope would be the case would be that all women in a voluntary situation could seek the kind of family planning assistance they need. It is not geared to any one group or minority in particular, it is allowing anybody to seek that service.

Senator CRANSTON. Thank you very much. You have been very helpful.

I take it that neither Mr. Randolph nor Mrs. Okrent are present. That being the case, they were scheduled to be witnesses, we will now recess until 5:30 this afternoon in this room, where we will receive testimony from one witness, the Reverend Monsignor James T. McHugh, director, Family Life Division, U.S. Catholic Conference.

I thank each and all of you for your presence and interest.

[Whereupon at 11:40 o'clock a.m., the subcommittee was recessed to reconvene at 5:30 p.m., the same day.]

AFTERNOON SESSION

Present: Senator Cranston.

Committee staff members present: Jonathan R. Steinberg, counsel to the subcommittee; Louise Ringwalt, research analyst; and Jay Cutler, minority counsel.

Senator CRANSTON. The committee will please come to order. I welcome all of you, and I welcome our witness for this late afternoon session, Monsignor James T. McHugh, director, Family Life Division, U.S. Catholic Conference.

I am delighted we were able to figure out a time at which we could get together, and I thank you for your help in the past.

You may proceed with your statement.

STATEMENT OF REV. MSGR. JAMES T. McHUGH, DIRECTOR, FAMILY LIFE DIVISION, U.S. CATHOLIC CONFERENCE

Monsignor McHUGH. Mr. Chairman, I am Msgr. James T. McHugh, director of the family life division of the U.S. Catholic Con-

ference, and I appear here today on behalf of the National Conference of Catholic Bishops to comment on S. 1708—the Family Planning Services and Population Research Amendments of 1973. S. 1708 is intended to extend and revise Public Law 91-572, the Family Planning Services and Population Research Act of 1970. Although it appears to be substantially similar to the 1970 act, there are a number of events that have occurred during these past 3 years that require a careful reexamination of the implementation of Public Law 91-572, and there are trends in our society that dictate caution and the need for certain restrictions in drawing up new legislation.

Moreover, there is an added difficulty in that the Family Planning Act of 1970 is one of a number of programs included in the Public Health Service Extension Act of 1973. The Extension Act passed the Senate by a vote of 72 to 19 and has received widespread public support. The 1-year extension of the family planning provisions received the endorsement of family planning groups, particularly Planned Parenthood Federation of America. The extension of present legislation for 1 year will no doubt afford more time to critically evaluate present programs. I would expect that additional hearings may be scheduled later in the year and would welcome the opportunity to testify at that time.

In terms of the legislation before us, it is important to note that the American birth rate has consistently declined since 1957, with sharp drops recorded during the past 2 years. The birth rate declined to 15.6 births per 1,000 population and the fertility rate was 73.4 births per 1,000 women 15-44 years of age at the end of 1972. The average number of children born to each family dropped to 2.03, below the replacement figure of 2.11. These are the lowest annual rates ever observed in the United States.

What is perhaps even more significant is that the number of children born dropped to 1.98 during the last half of 1972, and the most recent Census Bureau study, *Birth Expectations and Fertility: 1972* indicated that 70 percent of U.S. wives aged 18-24 said they expected to have no more than two children. The fact of a continuing drop in births is beyond question, but the significance of this continued decrease in fertility is uncertain. There is the real possibility that the continued drop, not significantly below the rate of population stabilization, may in fact be undesirable and disruptive in our country. My purpose in noting these statistics is not to speculate on what the decrease in births will ultimately lead to, but rather to note that the trend of a continuing birth rate decrease is neither tapering off nor reversing itself.

Nor is this decrease in birth rates simply a phenomenon of white, middle-income, educated Americans. Birth rates are also in decline among minority groups and ethnic groups, and the rates of out-of-wedlock pregnancy are similarly in decline (Current Population Reports of the U.S. Bureau of the Census, *Fertility Indicators—1970*, series P-23, No. 36, April 16, 1971).

It is unlikely that the overall decline in birth rates is attributable to the Family Planning Services and Population Research Act of 1970. But this review of declining birth rates indicates that we are not undergoing a population explosion, and that the majority of American women have been making and effectuating decisions regarding family size that are unprecedented in modern demographic

history. There is certainly no reason for an attitude of crisis or panic in regard to fertility. And the legislation before us today must be seen as serving very specific and limited purposes. It should not be construed as a necessary part of a national population control policy, nor should it claim to be the answer to problems of poverty, health care, population distribution or urban planning. I make these points because the Government, in the face of a continuous decrease in fertility rates, should be very careful that it does not encourage an even greater reduction in fertility. Moreover, the role of government should always be carefully restricted in the area of family planning because decisions concerning family size and the frequency of births are personal decisions based on religious convictions, cultural factors, the circumstances of family life and the hopes and aspirations of each couple. Government should assist couples in achieving their goals, rather than pose an external norm to which couples are expected to conform. To put it bluntly, we have had quite enough of the crisis rhetoric that is calculated to idealize the two-child family to the disadvantage of families of more than two children.

In light of the gaps in our knowledge concerning population dynamics, particularly the factors that lead to decreases in fertility rates, it is strange that the funding of research grants is held at the same level for fiscal year 1974 as for 1973, and that projected increases are rather small. It would seem that the government has a legitimate role in encouraging demographic research. However, research moneys should not be freely dispensed to pharmaceutical companies for the development of new contraceptive materials and compounds, since the primary motivation of the drug companies is to develop and market a new and financially successful product.

S. 1708 speaks of comprehensive family planning programs. However, this should not impede the Federal Government from funding specific programs that do not provide a comprehensive range of services, or are not a part of an agency or project offering comprehensive services. Moreover, comprehensive services should be understood to exclude abortion as a method of birth control, consistent with section 1008 of the Family Planning and Population Research Act of 1970, and it should also exclude sterilization.

The reason for this latter exclusion is that sterilization is a radical and almost irreversible procedure, one about which we know little in terms of physical or mental after effects, and one that, because of its near absolute destruction of the reproductive capacity, should not be promoted under government-financed projects. Moreover, given the primary orientation of S. 1708 toward servicing the needs of the poor, greater caution should be exercised in regard to sterilization as a means of birth control because it can too easily become a repressive measure used against poor people, minorities or the disadvantaged.

Section 1005 provides funds for informational and educational services. First of all, there should be a clear distinction between education and propaganda. Providing the American people, and especially students, with more information concerning population growth and distribution may be proper and useful. But very often, so-called population education is strongly biased in terms of population control or of specific programs to achieve a decrease in population. Moreover, educational programs dealing with population control and contraception

may too easily override parental rights and responsibilities when implemented by overeager or overzealous teachers. It's questionable as to whether anyone can develop "educational and informational materials on the causes and consequences of demographic characteristics and trends" with any real degree of accuracy at the present time. Certainly there exists no consensus as to the relation between environmental problems and population growth, nor has there emerged a conclusive explanation as to why and how birth rates rise and fall at various times.

In regard to the distribution of educational and informational materials to all persons desiring them, this should be limited to those who manifestly desire them, that is, those who ask for such materials. The materials themselves should be part of a wider educational effort wherein the individual can obtain medical examinations, advice, and therapy if needed.

Since the educational materials evidently include media presentations and materials for the schools, S. 1708 should make it clear that Government moneys are not to be used for school programs that will override parental values and convictions. Some appropriate method of previewing materials for school use should be established. In regard to population education directed toward the general population, a fair presentation of all sides of controversial issues should be insured.

The sections dealing with experimentation and voluntariness are of crucial importance to this legislation.

A Senate Subcommittee on Health recently held hearings on the experimental use of new drugs on human subjects. Dr. Charles Edwards, FDA Commissioner, described the policies of FDA and provided special information on two contraceptive drugs in the course of his testimony. In their own way, each drug raises a separate moral issue, while the FDA policies point up a further question.

The first drug is Depo-Provera, a derivative of progesterone that has been used in the treatment of specific cancers that affect only women. The drug received approval for such use from FDA in 1960 and in 1972. The drug has also been used as a contraceptive agent in other countries, though not approved in the United States for such purpose. The unique quality of this drug is that the patient is given an injection effective in preventing conception for about 3 months. The drug produced tumors in tests on dogs, though not in other animals.

A test of the drug for possible side effects is being conducted on a group of women in a Tennessee mental institution. The superintendent of the institution maintains that the women have been informed of the possible dangers, and asked to sign the consent forms required by FDA for the investigational use of new drugs in human subjects.

According to Dr. Edwards, when the dog studies indicated the development of tumors, an FDA Advisory Committee decided that long-term studies were necessary, and that on-going studies in humans would be allowed to continue only if the subjects were informed again of the dangers, and signed a new consent form. The experimentation in the mental institution is apparently continuing.

However, Marcia Greenberger, a lawyer, also testified before the Senate subcommittee that she had talked with six women at a birth control clinic in Tennessee, five of whom were already taking the drug. None of the six had ever seen the consent form furnished by Upjohn

Co., producer of the drug and apparently a collaborator in the testing. All were able to read it and understand it.

In a drug of this type, when serious side effects are found in animal studies, it is expected that FDA would restrict the experiments on human subjects. FDA explained that the human experimentation was allowed to continue because no other injectable contraceptive is available or forthcoming. FDA also maintains that the drug is being restricted to women who cannot use other types of contraceptives.

In summary then, FDA is allowing the continued experimentation with a dangerous drug on a group of women in a mental institution, and the use of the drug experimentally among women who sought family planning service from a county health department. These women never saw or signed consent forms.

The second drug is diethylstilbestrol (DES), a synthetic estrogen compound. Formerly used for certain gynecological disorders under proper controls, this drug can also be used after intercourse to inhibit pregnancy. But long-term studies of its use led to the discovery of cancer in the daughters of women who used the drug during their childbearing years. As a result, FDA issued warnings.

But DES was gaining in popularity as a morning-after pill, and it had never been submitted to FDA for clearance for this purpose. Studies indicate wide use on college campuses.

Because of its new found contraceptive potential, researchers worked out a new regimen for its post-coital use. Beginning 72 hours after intercourse, and in a continued low dosage for the next 5 days, the drug works effectively as a morning-after pill. There aren't likely to be any complications in the next generation, since the effectiveness of the drug precludes offspring. Dr. Edwards noted that one cannot tell what effects it may have on an already developing fetus, but an early abortion by conventional means should be seriously considered in such cases.

No one seems to know exactly how the drug works, but in the post-coital regimen it is quite clearly abortifacient. No one knows anything of its cancer-inducing properties either, but FDA has allowed its continued use because no one has proven it causes cancer when used post-coitally. Of course, there hasn't been enough time to study this yet, and the widespread use of the drug makes controlled study difficult. Moreover, a cancer specialist expressed opposition to further distribution of the drug.

However, FDA explains its leniency in these cases because each drug is a promising new contraceptive. FDA apparently assumes that more and newer contraceptive agents must be discovered and marketed. FDA's responsibility is to regulate the sale of drugs and the experimentation for drug development in order to safeguard the health of citizens. In view of the dangers to individuals, and also in view of FDA's demonstrated leniency in these matters, the sections concerning experimentations on human subjects in S. 1708 should be strengthened.

S. 1708 contains wording to safeguard voluntary participation in family planning programs. Although this language is directed toward protecting individuals, there is still the problem of the subtle coercion that results when a particular program is directed toward a special target group, that is, the poor, minority, or ethnic groups. There are at least two instances when a well-funded facility was set up with the intention that the proximity and availability would persuade people to use birth control and abortion services.

Section 1008 specifies that none of the funds appropriated under this title shall be used in programs where abortion is a method of family planning. This section should be strengthened to specifically prohibit the use of Government funds for research on abortifacient drugs, and to prohibit any family planning project funded under S. 1708 from providing abortion counseling or referral services.

Although the decisions of the U.S. Supreme Court in *Roe v. Wade* and *Doe v. Bolton* have established an atmosphere of permissive abortion, the majority of the court still maintained that abortion was a medical procedure directed toward safeguarding the woman's health. There is nothing to prove that the Court considered abortion as simply one more method of family planning.

Finally, in this regard, liberal abortion policies have proven to be counterproductive to family planning policies. This fact was demonstrated quite clearly by Daniel Callahan in his study of abortion practice throughout the world. Moreover, recent reports from Bulgaria, Hungary, and other Eastern European countries show a reversal of tightening up of liberal abortion laws because of negative demographic results. Evidence is also accumulating among doctors in Eastern Europe that frequent abortions increase the risk of premature births in later pregnancies.

At this point, I would like to expand on my prepared testimony.

Although the only reference in S. 1708 pertinent to abortion is to restate the prohibition of Government funding of programs where abortion is a method of birth control, additional issues have been raised in the course of these hearings. Thus, I feel compelled to emphasize that we find the opinion of the U.S. Supreme Court in *Wade* and *Bolton*, denying the humanity of the unborn child and thus absolutely denying any legal protection prior to viability, completely unacceptable.

Science has clearly proven that the fetus is a human being, and the court is beyond its competence in making the value judgment that the human life of the fetus does not deserve legal protection. The opinion of the majority is all the more objectionable since the Court was apparently racked by intrigue, intimidation, and compromise.

The unborn child is a human being from conception on, and deserves the protection of law. In light of the Court's opinion, the only way to achieve legal protection for the unborn child is by an amendment to the Constitution. We are most definitely in favor of an amendment that will supply the constitutional base for legal protection of the unborn child's right to life.

Another matter that I also wish to comment on is the amendment to the Public Health Services Extension Act of 1973, providing protection for hospitals and health care workers who refuse, on grounds of conscience and ethical convictions, to provide or participate in abortion services. This amendment was passed by the Senate, 92-1. However, a very determined effort is being made to obstruct the passage of this amendment on the House side.

This amendment is consistent with the emphasis on voluntary participation that has been a part of Public Law 91-572, and that is included in S. 1708. It is also consistent with the Supreme Court's holding in *Doe v. Bolton*.

So as to dispel any doubt in this committee or in any other area of government, I wish to emphasize again our support for constitutional protection for the right of hospitals and health care workers to refuse to take part in abortion procedures.

In conclusion, population growth and distribution are serious questions and policies related to population should be carefully formulated and open to continual reexamination. S. 1708 is a family planning bill, and is meant to provide assistance in one limited area of maternal health and human reproduction, that is, assistance primarily for the poor, to plan family size and the frequency of births voluntarily and with proper medical protection. S. 1708 is open to the dangers of all family planning activity, i.e., that it be used against minorities and the poor, that it be looked upon as a solution to other social problems, and that it interfere with the personal values and choices of married couples.

In reality, our Nation still needs a much more consistent and well-funded maternal health care and child welfare system that will support women and children, and we also need better welfare services to meet many other needs of the poor and disadvantaged. When housing, health care, education and employment services are absent or insufficient, family planning services can too easily be looked upon by those who promote them as a means of overcoming poverty. And they are frequently rejected by the poor who know that they are not.

Senator CRANSTON. I thank you on behalf of the subcommittee and personally for being with us and for that testimony.

We are also most appreciative of the opportunity to confer with you during the development of the provisions of S. 1708 and to have your counsel at that early stage. I hope we can continue this fruitful cooperation and I invite you to let us know of any further suggestions you may have on S. 1708 as it undergoes committee consideration.

In that connection, we would be very glad to consider any specific language you wish to propose to us to amend the bill to carry out the suggestions in your testimony.

You state that it is strange that funding of research grants is held at the same level for fiscal year 1974 as for fiscal year 1973. Are you talking about the President's budget request?

Monsignor McHUGH. No, I was talking about the text of S. 1708, as I found it in the Congressional Record.

Senator CRANSTON. There has not yet been any money appropriated at any time under research provisions of—

Monsignor McHUGH. I think these are projected figures.

Senator CRANSTON. I was just explaining, the reason we held it at those levels was that there had never been any money appropriated so we did not see any particular reason to increase the authorization at this point. I hope that I can take it, however, that you support an increased appropriation for research in population dynamics or at least you feel more should be spent than we are talking about on that subject?

Monsignor McHUGH. I feel that the allocation of moneys on the part of the Government is appropriate for research, both demographic research and research into basic human reproduction, biology, physiology. I do not consider it appropriate for Government to be funding drug companies so they can develop new, financially successful prod-

ucts. I find in the past that if that has not been the actual case, it certainly has been the proposal on the part of the drug companies.

Senator CRANSTON. What authorization figures do you feel might be appropriate in the area—

Monsignor McHUGH. I really did not make any projection. I did not think of it in terms of detailed comparisons or projections. I just observed that to hold it at the same level with moderate increases here while expanding into the allocations in other areas struck me as out of balance.

Senator CRANSTON. The President's budget suggests no increase over the \$38 million appropriated for research in fiscal year 1973.

Also you expressed the view that research moneys should not be freely dispensed to pharmaceutical companies for contraceptive development. Would you then support the provision of S. 1708 on page 12 which limits the amount of any such support by the Federal Government to a for-profit entity to 50 percent of the total research cost? Do you think even that is more than we should be doing?

Monsignor McHUGH. I do not think we should be funding drug companies at all. I do not think it is appropriate to use tax moneys to develop what is basically a commercial product for the drug company. It is like taking highway fund money, giving it to auto manufacturers, so they can develop better cars to drive on the highways. I cannot see supporting research in chemical or mechanical devices for contraception.

Senator CRANSTON. Still, you expressed concern about the meaning of the word "comprehensive" in the declaration of purpose in section 1000, clause 4, in S. 1708. We have no intention of changing the present law or its interpretation by use of that word in that place. That clause is identical to clause No. 4 in section 2 of Public Law 91-572. Moreover the operative language, rather than purpose clause language, in the bill is in section 1002(a), which authorizes grants and contracts to assist in the establishment of and operation of voluntary family planning programs and projects.

This language is identical to that in present section 1001(a) in title X.

I appreciate your discussion of the ethical problems involved in research on new contraceptives and the use of experimental drugs. I think we have dealt with those subjects adequately in clauses 6 and 7 of section 1006(c), but as I said earlier, we would welcome specific language to improve these provisions.

Also I have called your testimony to Senator Kennedy's attention in connection with the Health Subcommittee's investigation of human experimentation.

You caution about implicit coercion in the location of family planning projects in areas so as to be accessible to low-income families, as required in section 1006(c) (4) in the bill. As you know, we think this approach in trying to fulfill our objective of making voluntary services available to those who want but cannot afford them is preferable to stating a priority for low-income persons and then making inquiries about income level to persons seeking services.

Would you care to comment on those alternatives?

Monsignor McHUGH. I am not making an observation in regard to your new thrust toward location, rather than investigation or questioning. But I have two specific instances in mind.

The first case has to do with a community interagency council here in the District of Columbia that is a coalition of family planning agencies in the area. Approximately 18 months ago the executive director, who also was employed by one of the local universities, publicly asserted that much more should be done to encourage the poor to use birth control and that there ought to be a more aggressive program directed at the poor not only to get them to use birth control but to avail themselves of the abortion facilities available in this town.

The question of the use of the abortion facilities was something of a *cause célèbre* because it was obviously in complete opposition to Public Law 91-572. I cite the instance because it is one of those instances where the aggressive pursuit of the population to make use of the services at their disposal reaches over from enabling to propagandizing to perhaps subtle diversion.

A similar instance took place in New York on the East Side where a family planning agency was funded with the intention of moving it close to the poor and encouraging the use of all kinds of contraceptive services under this new well funded agency. Once again I think that the line was fudged a little bit. We are not any longer just dealing with providing services on a voluntary basis to those who wish to use them, but there is an aggressive program outlined to encourage the use. I think these are things that have to be watched and that is why I raise this point. I was not really reflecting on your alternate here in preference to actually asking people what their income level is.

Senator CRANSTON. You would not feel that the mere location so as to be accessible would imply any coercion, I assume?

Monsignor McHUGH. I would say it might. Just putting up a building in a ghetto does not necessarily mean you are coercing anybody, but I think the warning is placed here for what the personnel of such projects might do, and also for the underlying intent of the whole operation. It is one thing to provide any kind of service to any target group, but it is another thing to reach out to try to persuade that group to make use of the service.

Senator CRANSTON. Do you agree that there is a problem about making inquiries about income?

Monsignor McHUGH. Yes, I assume there is a problem. I am not suggesting that poor people be in any way treated in an undignified fashion.

Senator CRANSTON. Thank you very much. I agree with your caveat about the danger that family planning will be used against minorities and the poor and be looked upon as a solution to other social problems. In my opening statement this morning I commented on this, and I would like to read briefly part of what I said when the hearing started out this morning and then ask your comments. That portion of my statement was as follows:

Although I look forward to questioning the Administration on this approach, I must say at this point that I am extremely concerned about the apparent underlying philosophy that federal government participation in the provision of family planning services attempts to walk a highly tenuous and perilous tight rope between the need for services for those who cannot afford them, on the one hand, and on the other hand the great concern that exists in minority groups and other poverty communities that some people have a hidden agenda for federal involvement in the provision of family planning services, namely, family planning is fine for the blacks, the brown and the poor, who already drain too much of our eco-

conomic resources in poverty programs, welfare payments and services and other special programs. I categorically reject any such agenda—hidden or otherwise—and any such philosophy. Although I agree that our primary obligation is to get quality services to those who can least afford them, I cannot endorse a policy which identifies the major federal family planning efforts with the elimination of poverty and the public assistance program. I recognize that these sorts of distinctions are not easily made. In many respects it is a question of tone and program emphasis. But the underlying point is of critical importance, and we must not lose sight of it merely because it is a complicated problem not susceptible to facile resolution.

Monsignor McHUGH. I recognize your determination in this area, Senator Cranston, but I think that both of us are saying the same thing, that there is an inherent danger in family planning legislation, that those who administer it may have a different orientation than those who establish or formulate it. So though your intentions might be the best, there is a need for control over those who are going to administer or utilize moneys provided under this legislation. I think second, that anyone who regularly reads the family planning literature detects the note that family planning assistance is an economic effort to get rid of poverty. In other words, if we can limit family size among the most improverished of our people that somehow or other we are making a good investment. It is going to save us money later in welfare, education and welfare services, whatever have you. I think this type of thinking is frequently present, and it is a philosophy that I reject very strongly. It seems to me that you are saying the same thing. I think that is the reason for being very cautious about legislation of this type.

I do not think that you can perfectly dissuade people who take that approach to it either. It seems to me that the economic concern recurs even in testimony before a subcommittee such as this.

Senator CRANSTON. Yes, it does. It seems to me that there is a danger that we recognize together and that that danger is heightened or would be heightened if the administration's proposals were put into effect and the major Federal effort was placed in a welfare and medicaid program.

Monsignor McHUGH. I am not inclined to defend the administration's policy here or elsewhere. I do think that there is always a greater danger when family planning is linked with other welfare services. That only tends to increase the danger, yet at the same time I think it is fair to say that many who assess family planning as part of a larger health care service do not always show as great a commitment to the rest of the health care services as to family planning. That is not for your subcommittee, but has to do with other agencies of our government.

Senator CRANSTON. Thank you. Do you define abortifacient drugs to include IUD's?

Monsignor McHUGH. And IUD is not a drug really, it is a mechanical—

Senator CRANSTON. Well, leave off the word "drug," is it an abortifacient?

Monsignor McHUGH. I think there is substantial evidence today to indicate it has abortifacient qualities. I think the whole question of an IUD is one of those areas in which the conclusive evidence is not in yet as to how it works precisely. I would not try to solve the problem.

Senator CRANSTON. Do you have a position on whether an IUD is something that should or should not be prescribed in Federal programs?

Monsignor McHUGH. I would say insofar as we are still in doubt, that we know it does have an abortifacient effect, we should avoid the use of the IUD as a contraceptive.

Senator CRANSTON. You seem to call for a comprehensive and well funded program of maternal and child health care. I just want to say in closing this afternoon's hearing that I certainly agree with that, and have thus included in section 1006(c) clause (3) a requirement that family planning services projects and programs funded under title X shall make maximum efforts to establish arrangements for the provision of exactly those services, either directly or more likely through linkages with other health providers to those persons receiving voluntary family planning services under title X.

I have no further questions. I do look forward to hearing more if you have further thoughts specifically on language, and I thank you very, very much for helping us.

We now stand in recess until 2 o'clock tomorrow afternoon in room 4200.

Thank you all very, very much.

[Whereupon at 6:15 p.m. the hearing was recessed to reconvene on Thursday, May 10, 1973 at 2 p.m.]

FAMILY PLANNING SERVICES AND POPULATION RESEARCH AMENDMENTS OF 1973

THURSDAY, MAY 10, 1973

U.S. SENATE,
SPECIAL SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:27 p.m., in room 4200, Dirksen Building, Senator Alan Cranston presiding.

Present: Senator Cranston.

Committee staff members present: Jonathan R. Steinberg, counsel to the subcommittee; Louise Ringwalt, research analyst; and Jay Cutler, minority counsel.

Senator CRANSTON. The hearing will please come to order. I regret the brief delay in starting. It was caused by a rolcall that I had to attend.

This afternoon we will be hearing from representatives of groups who have considerable interest in the legislation before the subcommittee.

These are the "right to life" groups and womens organizations.

I am delighted that the response to my invitation to these organizations to testify was enthusiastic and that we have so many leaders here today who will identify those issues to which they attach primary concern and give us their insight into these issues.

Several additional groups were unable to attend the hearings from whom we had hoped to hear but have advised they will provide the subcommittee with written statements for the record. These are Mr. Joaquin Acosta, from the Right to Life League of Southern California, Dr. Joseph Stantan, of the Value of Life Committee in Massachusetts, and Mr. Jerry Frizell, of the Illinois Right to Life Committee and Mr. Joseph A. Lampe, executive director, Minnesota Citizens Concerned for Life.

The hearings today are scheduled for 3 hours. Representatives of the right to life groups will appear first and at the midway point the representatives of women's organizations will appear.

There are six groups who will be testifying from the Right to Life Organizations. By dividing the time equally among these six groups, each witness may use up to 15 minutes, unless you agree among yourselves otherwise.

There are 10 representatives of womens organizations and by dividing time equally among these 10 organizations, each witness may use up to 9 minutes, unless you agree among yourselves otherwise.

I appreciate your coming today.

We will now hear from the first witness. That is Mrs. Randy Engel, executive director, U.S. Coalition for Life.

STATEMENT OF MRS. RANDY ENGEL, EXECUTIVE DIRECTOR, U.S. COALITION FOR LIFE, ACCOMPANIED BY JAMES McCLURE

Mrs. ENGEL. Are any of the other Senators on the subcommittee to appear today?

Senator CRANSTON. I do not know. There are some conflicts with other committees and there is some action on the Senate floor.

Mrs. ENGEL. Mr. Chairman and members of the subcommittee, who are not here—

Senator CRANSTON. Let me assure you that staff representatives are here for the Senators, and the Senators will have an opportunity to review the record.

Minority counsel is here.

Mrs. ENGEL. Good.

I appear before you today to discuss the "family planning services and population research amendments of 1973" which would extend appropriations authorizations for 3 fiscal years and serve to consolidate existing family planning-population research, projects and services under the umbrella of a new Federal office—the Office of Family Planning and Population Science, with the assistance of a National Advisory Council.

I have no doubt that the majority of those who support this bill, as distinguished from the framers of this piece of legislation, are as concerned for the welfare of this Nation as those Members of Congress who passed the original Family Planning and Population Services Act of 1970 (Tydings bill) to which was attached an abortion prohibition amendment by voice vote in both Houses.

And it is exactly out of these same motives and with the same degree of concern, that I ask you to consider anew the whirlwind of moral and physical corruption and destruction that this act has wrought upon this country in the name of freedom and dignity of the individual and support for the family unit.

Gentlemen, I have before me a 200-page report replete with necessary documentation, which highlights the gross violations of the Tydings Act by governmental and private and nonprofit entities. Violations which include:

The funding of abortifacient research and actual clinical testing by federally supported hospitals, clinics, university-based medical centers at home and abroad, and profitmaking pharmaceutical companies. The majority of experimentation, without full and informed consent, is being conducted on recipients of welfare, the retarded and so-called "sexually active" young people—the very same "target population" singled out for special attention in the "family planning services and population research amendments of 1973."

The massive and blatantly unconstitutional violation of family privacy by the Federal Government and the assault on marital privacy by public and private agencies receiving funds under the Tydings Act.

With regard to individual liberty, I understand that Frank Carlucci, Undersecretary of HEW, together with members of the general council, have already found it necessary to give a ruling in at least two cases of abortion carried out without the full consent or knowledge of the patients. In each case the physicians base their action on the

recent Supreme Court decision of *Roe v. Wade*, which provides that a women's attending physician shall make the determining decision on abortion. I ask you to investigate this matter further and enter into the record the specific details regarding these and other cases with proper safeguards across to protect the privacy of patients concerned, Mr. Chairman.

The other violations include the use of social security numbers to identify, and continually monitor the family planning activities of patients including home visitations by social workers when clinic patients fail to respond promptly to the second call of the computers of the State welfare agency. It includes attempts by Federal agencies to cajole private physicians into revealing for the public record the sexual patterns and contraceptive habits of the patients.

Violations which include the establishment and funding of teenage fornication and abortion centers such as Teen Scene of Chicago, operated by Planned Parenthood, the latter of which also trains abortion counselors on HEW and AID funds.

Violations which include the release of OEO mailing lists to private agencies associated with condom distributors—in this case the target group are young, black, disadvantaged males.

Violations which include federally supported experimentation on live babies—survivors in most cases of hysterectomy or prostaglandin abortions which deliver the live baby intact. Such experiments are funded by the National Institutes of Health. As is the case with abortifacient research, what the experimenters can't get away with in this country, they get away with in European or third world nations, again, with the American taxpayers footing the bill.

These live babies, whose only claim is that they are unwanted or defective, are being dissected alive without benefit of anesthesia, they are fed into tissue grinders, their skulls are partially removed in order to conduct neurological studies, their organs ripped from their tiny bodies, and their bodies injected with a variety of viruses after which they are killed and their tissue used to produce polio vaccine and other preparations.

Violations which include the awarding of long-term Federal grants to well-known advocates of population control including compulsory abortions.

In 1969, Dr. Kingsley Davis of the University of California, Berkeley received a 5-year grant totaling \$337,652 titled "Goals and Conditions of Population Control." Dr. Davis is perhaps best remembered for his suggestion that unwed mothers be compulsorily aborted.

Last year the Agency for International Development awarded a \$2 million grant to the Association for Voluntary Sterilization (AVS) headed by John R. Rague, who is now executive director of NPG, (negative population growth), a group which advocates compulsory population control with a maximum of one child per family.

In studying HEW's 5-year family planning and population research program one notes with alarm the vast number of grants awarded to studies of reproductive behavior in both human and animal populations.

I've enclosed in my report to this subcommittee a table prepared in the form of a memo from F.S. Jaffe of P.P. to Bernard Berelson, who served on the Rockefeller Population Commission and is a member of Rockefeller's Population Council (John D. Rockefeller III).

Written in March of 1969, the table details the effects of a variety of population control measures on U.S. fertility. Some of those measures include payments to encourage sterilization, contraception, and abortion and encouraging homosexuality as well as economic and social penalties after the State-proscribed number of children allotted per couple has been reached. (See p. 493.)

I ask you gentlemen, what are the purposes of such studies and Federal grants if not to impose compulsory population control upon the citizens of this Nation? If Dr. Hellman of the Office of Population Affairs has drafted such plans for compulsory population control in the United States, in order to achieve an optimum population by the year 2000, I'd like to know about them and I'm sure you would too. Particularly since this bill now before you would set up the mechanism by which such controls could be employed in the form of a national population advisory council and new consolidated agencies for family planning and population science, terms for which no definition are provided.

Lastly, and perhaps most importantly, the funding of the Tydings Act has made possible the psychological rape of our Nation's young people who are not just being taught that people are polluters, but that people are pollutants. This is a generation which is being indoctrinated in a new totalitarian scheme under the guise of planet management in which spaceship Earth is cherished while its crew goes to hell in a breadbasket.

I ask you plainly, with regard to the Environmental Education Act, what value system is the State pressing forth and what happens if those values based on a new religion of the ecosystem comes in conflict with traditional political, social, economic, and religious values? According to the U.S. Office of Education, the latter must give way to the former.

In conclusion, let me say a word about the utter uselessness of the Dingell amendment prohibiting abortion as a method of family planning, which I believe will probably be attacked as unconstitutional as soon as Congress would pass this appropriation bill.

Gentlemen, it is time to stop playing word games—deadly word games in which the killing of this Nation's unborn is carried out under such euphemisms as "Menstrual extraction, (M.R.)" and "post-conceptive family planning," by which millions of women are being fooled into thinking that they are practicing contraception when indeed they are practicing repeated early abortions. Such women include users of the IUD and so-called minipills, both of which are approved methods funded by the Tydings Act.

I understand that a 1-year extension of the Tydings Act has already passed both Houses. Considering the gravity of the charges complete with documentation that I am presenting to this subcommittee, I hereby wish to make it a matter of public record, that the coalition with whatever congressional support it can muster, calls upon President Nixon to immediately impound funds appropriated under this extension until such time as a full congressional investigation including full financial audits are made by the GSA of all funds which to date have been appropriated under the original Tydings Act.

We are now in the midst of the Watergate scandal, with subsequent housecleaning at the executive branch of Government. It is high time,

I believe, to do a little housecleaning in the Department of HEW, beginning with the office of Dr. Louis Hellman, Office of Population Affairs.

The coalition supports the American public's right to know; the members of this subcommittee have a right to know; to know before 1 more cent of Federal funds are spent on the antilife boondoggles I have briefly outlined.

Thank you.

Senator CRANSTON. Thank you, very, very much, Mrs. Engel. The President has requested funding under this act, so I think it is somewhat doubtful that he would choose to impound funds for implementation of the act. I want to say to you, Mrs. Engel, that we will submit your testimony to the Department of Health, Education, and Welfare and ask them for a full and detailed report on each of the many disturbing and serious reports that you cited in your testimony.

I would appreciate it also if you would leave with us a copy of the 200-page report from which you cited.

Mrs. ENGEL. May I ask, would you consider the request that I made with regard to looking into the areas of compulsory abortions, at least abortions carried out without the knowledge or consent of the patients involved?

Senator CRANSTON. That will be among the matters we will submit to the Secretary for a report.

Mrs. ENGEL. Will that be entered into the record?

Senator CRANSTON. The response will be.

Mrs. ENGEL. Good.

Senator CRANSTON. We will now hear from Mr. Joe Bowman, chairman, Georgia Right to Life Committee Inc., and member of the board of directors of National Right to Life Committee, Inc., accompanied by Mr. John Short, publisher, Triumph magazine.

STATEMENT OF JOE BOWMAN, CHAIRMAN, GEORGIA RIGHT TO LIFE COMMITTEE, INC., ACCOMPANIED BY JOHN SHORT, PUBLISHER, TRIUMPH MAGAZINE

Mr. BOWMAN. My name is Joe Bowman. I am chairman of the Georgia Right to Life Committee, and a member of the executive board of the National Right to Life Committee.

My testimony will be brief, and will concentrate on only a small portion of the proposed bill. My brevity is necessitated by the short notice given to me about these hearings. I was contacted by the chairman's office on May 1, only 9 days ago. Not until last Friday did I receive the committee print of the bill. I wonder if it could be possible that the proabortion witnesses were given such short notice also. Is it conceivable that Planned Parenthood was given less than 2 weeks to prepare? Or did they, in fact, participate in the drafting of this bill, either covertly or overtly? I am compelled to appear before you under protest.

Section 1008, which prohibits the use of funds for programs involving abortion, is identical in wording to the existing law. And it will be as ineffective. Organizations such as Planned Parenthood, which vigorously promotes abortion through its propaganda and provides abortion in its clinics, can easily circumvent the intent of this section

by hiring a competent accountant. In 1971, Dr. Alan Guttmacher president of Planned Parenthood, stated that "these Government grants free unrestricted citizens' contributions to finance new areas of service excluded from Government subsidy."¹ What could Dr. Guttmacher have meant, but abortion clinics?

One piece of proabortion propaganda available from Planned Parenthood is a "comicbook" entitled "Ten Heavy Facts About Sex." Although its listed price is 25 cents, Planned Parenthood gives it away. Besides dealing with penis size² and masturbation,³ this "comic book" contains the following information on abortion: "We think having an abortion is more moral than bringing an unwanted child into this world. Having a medical abortion before the 20th week is safer than giving birth."⁴ In one sentence, they provide our youth with a standard of "morality." And, in the next, they practice deception. No objective study, based upon reliable data, has ever shown abortion, at any stage, to be safer than childbirth. On the contrary, it has been conclusively proven that the rates of maternal morbidity and mortality are far lower for mothers who deliver their children than for those who abort, to say nothing of the mortality rate of aborted children. An excellent study on this subject was contained in the latest issue of "Marriage and Family Newsletter," which I include in my written evidence.⁵

Emory University's family planning program also provides abortion information to our youth through a magazine entitled "What's Happening," which is funded by a grant from the Department of Health, Education, and Welfare.⁶ After disposing of the alternatives to abortion in two lines," "What's Happening" then glosses over the seriousness of abortion and tells the young mother-not-to-be what number to call if she wants one.⁷

Not only does HEW subsidize the dissemination of proabortion propaganda, it also funds its compilation. In July 1972, the Atlanta Constitution reported that HEW had granted \$185,000 to four Emory University researchers for a 2-year study of the comparative psychological effects of abortion and the bearing of an unwanted child.⁸ Georgia Right to Life sought to have the grant rescinded for two reasons. First, two of the principal researchers were known to be pro-abortion. One of them, Dr. Charles Butler, ran the abortion clinic at Grady Memorial Hospital in Atlanta. The other, Dr. Lawrence Baker, had debated prolife speakers including myself on numerous occasions.

¹ Randy Engle, *A Pro-Life Report on Population Growth and the American Future*, (Export, Pa., 1972), p. 6.

² Sol Gordon, *Ten Heavy Facts About Sex*, (Syracuse, N.Y.: Family Planning and Population Information Center, 1971), p. 10 (un-numbered).

³ *Ibid.*, p. 6.

⁴ *Ibid.*, p. 14.

⁵ Margaret and Arthur Wynn, "Some Consequences of Induced Abortion to Children Born Subsequently", *Marriage and Family Newsletter*, February, March, April 1973.

⁶ *What's Happening*, Emory University School of Medicine, Department of Gynecology and Obstetrics, Family Planning program, inside front cover.

⁷ *Ibid.*, p. 20 (see also inside back cover).

⁸ "Grant Given Emory For Abortion Study", *The Atlanta Constitution* (June 29 1972), p. 9-B.

NOTE.—Because of the length of the material included in footnotes 2, 5, and 6, these publications are included in the official files of the subcommittee.

Our second objection was that even if there was no question about the objectivity of the researchers, the validity of the study would still be in doubt based upon its short duration. Two years is hardly long enough for some of the serious psychological sequelae of abortion to manifest themselves.

In effect, our Government has been indirectly subsidizing both the promotion and the performance of abortions. Section 1008 should be modified to prohibit funds being allocated to organizations which, in any way, promote abortion. If the prohibition is not extended in this manner, organizations such as Planned Parenthood and Emory Family Planning will continue to get around the prohibition by simple bookkeeping.

The fact that I confined my objections solely to this one section should not be taken as my tacit approval of the rest of the bill. Rather, it indicates the lack of advance notice mentioned earlier. I reiterate my protest and request that either these hearings be extended by this subcommittee, or that additional hearings be scheduled by the full Committee on Labor and Public Welfare.

If there are no questions, I yield the balance of my time to Mr. John Short, who will testify on some aspects of voluntarism. Thank you.

[The following material was subsequently supplied for the record:]

[From the Atlanta Constitution, June 29, 1972]

GRANT GIVEN EMORY FOR ABORTION STUDY

An interdisciplinary team of investigators from the Department of Gynecology and Obstetrics in the Emory University School of Medicine has been awarded a grant to study the comparative psychological effects of abortion and unwanted births.

The three-year study will focus on low-income, unwed, pregnant women at Grady Memorial Hospital.

The project is supported by a \$185,000 grant from the Maternal and Child Health Service of the Department of Health, Education and Welfare.

Results of the study will be used to form an objective basis of information on which women can be counseled as to the best possible course to be followed when faced with an unwanted pregnancy.

Approximately 200 women approved for legal abortion will be compared with a matched control group of women who elect to carry their pregnancies to term.

The women will be given psychological tests both before and after termination of their pregnancies and extensive sociological data will be obtained.

"The research is aimed at improving our understanding of how women adjust socially and emotionally to unwanted pregnancy and abortion," according to Dr. William L. Graves, a sociologist in Emory's Department of Gynecology and Obstetrics.

"While legal abortion might seem the perfect alternative to unwanted pregnancy, there are many psychiatrists who believe that, for some women, having an abortion may be damaging psychologically as bearing an unwanted child," Graves commented.

Principal researchers for the project include Graves, Dr. Charles W. Butler, a psychiatrist, Dr. John W. Epps, a psychologist, and Dr. Lawrence D. Baker, a physician.

Graves said that the increasing availability of legal abortions across the country has created a dilemma for persons responsible for counseling women with unwanted pregnancies.

Senator CRANSTON. I would like to say that the record of this hearing will be kept open for 2 weeks, so there will be ample time for you to submit any statement you wish for that record and you have that time to study the legislation and to make any comments you feel are appropriate.

Mr. BOWMAN. Thank you.

Senator CRANSTON. Our next witness is Mr. John Short.

**STATEMENT OF JOHN SHORT, PUBLISHER, TRIUMPH MAGAZINE;
CHAIRMAN, POSITIVE ALTERNATIVES COMMITTEE, NEW YORK
STATE RIGHT-TO-LIFE**

Mr. SHORT. I appreciate the opportunity to testify. My name is John Short.

Senator CRANSTON. You have 8 minutes for your testimony.

Mr. SHORT. The other right-to-life speakers said I could finish in full regardless of time because our combined time will not be going over 1 hour and a half. I am currently the publisher of Triumph magazine, formerly accounting executive of Nassau County Social Services in New York State. I was fired from my government position in an issue directly related to this legislation, because I refused to perform an illegal act, refused to violate the dictates of my conscience and the principles of my religious belief. In this regard the questionable ethics and corruption of Watergate on the national administrative level are child's play compared to the questionable ethics and corruption at the administration and Supreme Court level in Nassau County, N.Y., corruption which stands a good chance of engulfing the Supreme Court on the Federal level. Of essence is the fact that this corruption relates directly to the legislation you are considering today.

With the passage of Public Law 91-572 this country crossed the threshold into the world of population manipulation. In Paul Marx's book, "The Death Peddlers," which is supported by the actual taping of a conference of population controllers, the people who were responsible for passage of the bill which should now be defeated, Marx gives verbatim accounts of the fact that Government funding of research into contraception granted by this bill has provided the long-sought fiscal vehicle for the population manipulators. How they could best milk the taxpayer and manipulate these funds—and funds obtained from other Government programs—to bring about mandated abortion, was set forth on January 21, 1971, in an unbelievable speech by Senator Robert Packwood at a symposium addressing itself to population manipulation via any and all means possible. In his remarks concerning the Tydings Family Planning and Population Act—for family planning and population research, Packwood said he abhorred the fact that the bill excluded any moneys for abortions. He detailed suggestions for violating the intent of the bill by using tactics such as the following: "If a national grant were made to Chicago Planned Parenthood they could use the money for other purposes while using their current moneys to promote abortions. This would give every Congressman a way out." Again "Various health accounts funnel money

that can be used for abortion—the Public Health Services accounts likewise grant various State services money.” Finally—“section 5 under the guise of infant care and maternal health be used to make funds available for abortion services and avoid using the word ‘abortion’ in connection with these programs.”

[The material by Senator Packwood referred to follows:]

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United States Senate

COMMITTEE ON FINANCE
 WASHINGTON, D.C. 20510

July 10, 1973

The Honorable Alan Cranston
 Chairman
 Subcommittee on Human Resources
 Senate Labor and Public Welfare
 Committee
 United States Senate

Dear Alan:

With your permission, I would like to clarify the record with reference to testimony presented to your Subcommittee on May 10, 1973, by Mr. John Short, Publisher of Triumph Magazine.

Mr. Short describes my remarks at what he calls "a symposium addressing itself to population manipulation via any and all means possible." You should know that the symposium was sponsored by the U.C.L.A. School of Medicine, in January, 1971, and was entitled, "Therapeutic Abortion: A Symposium on Implementation." The Symposium was held at a time when abortion laws were being revised and liberalized around the Nation, but before the Supreme Court decision of this last January. Some of the questions addressed included the impact of strict abortion laws on the poor versus the wealthy and middle class woman; what medical or logistic problems might develop as a result of liberalized abortion policies; what should be the role of counselors should abortion patients necessarily be hospitalized, etc. etc.

Nearly all the Symposium speakers were physicians, and the emphasis was clearly medical in nature. I was asked, however, to comment on the role of the federal government in the abortion issue, and did so to the best of my ability. Here, too, clarification is necessary, as Mr. Short's description of my remarks is grossly distorted and his alleged quotations entirely inaccurate.

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The Honorable Alan Cranston
July 10, 1973

My opening statement asserted my judgement, in January, 1971, that "Within the next two to five years, we are going to have legalized abortion." With the Supreme Court now having handed down its decision throwing out restrictive state abortion laws, I don't think my prediction was very far off the mark. And perhaps that is what is really bothering Mr. Short. The remainder of my comments described the rather scant discernible federal policy on abortion, the Tydings Act prohibition on abortion (which Mr. Short insists I am somehow trying to subvert--a most interesting irony, since I participated very closely in passage of this legislation), the importance of comprehensive family planning services--including abortion as a back-up measure--in reducing infant and maternal mortality (with references to the New York experience as of that date), and other pertinent aspects relating to abortion which should be considered in implementing any abortion policy.

For the record, I would also like to emphasize that with adequate funds for comprehensive family planning information and services for all who want, but do not currently have access to them, we could virtually eliminate the need for abortions. I had fervently hoped that following the Supreme Court's decision, opponents of legalized abortion would begin to work with us to make family planning services available to all, so that abortions might one day not be necessary. Unfortunately, however, many opponents of legalized abortion have chosen to pursue other courses, designed to override the Supreme Court, rather than the far more constructive approach of helping to prevent unwanted pregnancies.

I very sincerely appreciate having the opportunity to clarify the record.

Cordially,


BOB PACKWOOD

BP/cbb

Senator CRANSTON. There is a rollcall I have to go to. I will come back. We have to recess briefly while I attend to my other duties.

[Whereupon, a brief recess was taken.]

Senator CRANSTON. The hearing will please come to order. Please forgive the interruption and please proceed with your statement.

Mr. SHORT. I was in the middle of giving the last of three quotes from Senator Packwood. This is the last quote I will refer to. He emphasized that "we can talk about the welfare of maternal health when what we are doing is making money possible for abortion." Senator Packwood continuously coached them by emphasizing that Public Law 91-572's prohibition against abortion only said "none of the funds under *this* (the italic emphasis is Packwood's) title shall be used where abortion is a means of family planning." The challenge he offered to population manipulators was to use their freed funds to attack the various health programs such as medicaid where the traditional understanding of the use of these funds was for life-saving and life-supporting services. He encouraged them to challenge this definition through the courts so that it would be redefined to allow for population manipulation through abortion, contraception, sterilization. This attempt to redirect life-saving and life-supporting programs to be life-preventing and life-destroying programs has been pursued diligently by the likes of population manipulators such as the Civil Liberties Union, Bill Baird, and sympathetic bureaucratic administrators within the Nassau County and New York State administrative and judicial systems.

The major point was that they should dump the term "therapeutic abortion" in favor of the term "legal abortion." Naturally any group could work for the implementation of that which is legal and even more naturally at some point an elite corps of Government officials could at an opportune time step in and mandate that which is legal.

Their success has been so dramatic that the mandatory use of tax funds by all levels of government for abortion on demand for the recipient of medicaid and for abortion on command by the state for all family planning recipients may well be the outcome of an improperly presented and improperly defended case now before the U.S. Supreme Court. It had its beginning in Public Law 91-572 which must be removed. In fact, if the Supreme Court rules in favor of tax supported exterminative medical procedures and against the traditional position that medicaid exists to provide the needy with necessary life-saving and life supporting services then it places the recipient and the state in the position of requesting, requiring or receiving any and all types of elective surgery at will, and at taxpayers expense. The recipients so-called gains would be shortlived, however, for the state would then be in a position to effect genocide by the elimination of those lives considered void of value, such as the mentally retarded and the incurably ill or handicapped, the socially unproductive, the medicaid and family planning recipient, the ideological unwanted and then the group that you and I feel we best fit into. This case before the Supreme Court is commonly known as the *Klein* case and the Docket No. 72-770. I am currently in the process of attempting to have the Supreme Court properly address itself to the numerous constitutional questions involved, such as the proper use of tax money, the invasion of privacy, the violation of the principle of separation

of church and state, as well as the fact that the case the court has before it has been improperly and untruthfully presented and that the county has actually pleaded contra positions in different courts on the same issue.

A case in point is the case whereby I was dismissed from my job as accounting executive of the Nassau County Department of Social Services for refusing to perform an illegal act, which refusal forced the county into the *Klein* case whereby they were put into the position of defending a law they were knowingly and willingly violating. Is it any wonder the county "lost" the *Klein* case. I refused to perform an illegal act, refused to violate my conscience and the dictates of my religious beliefs and objected to the invasion of the right of privacy of those who happen to be economically less fortunate than myself. My dismissal by Nassau County once and for all destroys the myth that voluntarism either exists or will be tolerated by the population manipulator. There is not voluntarism for either the recipient, the conscience oriented administrator or the offended taxpayer. "Brave New World," 1984, "Future Shock; Big Brother and their "new speak" language became firmly established as the legal language of our day in a decision dated March 16, 1973 by Justice Harnett of the New York State Supreme Court, Nassau County branch.

A brief review of the major points in my case demonstrates quite clearly not only the non-existence of voluntarism in conjunction with legalized and tax-supported abortion, contraception and sterilization, but also the inevitable mandating by the State that a citizen perform or participate in an act contrary to his legal right, conscience and religious beliefs. Several issues were involved in my trial. First, the issue of the IUD as a family planning device. Initially the county claimed the IUD (Interuterine Device) was in the program and it was not abortive. Later after expert testimony they conceded the IUD was abortive and then reversed their story and claimed the IUD was not in the program. Finally they admitted that the IUD was in the program and was abortive which left them with the need to justify this illegality. Here we find Justice Harnett a better master of science fiction than either Huxley or Wells for this is what Justice Harnett then said "while experts called by Short testified that the operational effect of IUD occurs after conception and the corrected disciplinary hearing reflected some IUD dispensing at the Family Planning Center there was nothing and is yet nothing, to support his (my) contention that the use of the IUD is legally an abortion activity. Differences between a medical classification and its legal counterpart often occurred when the societal impact of the legal characterization is deemed unwarranted, notwithstanding the accuracy of scientific technology." In plain language what Judge Hartnett is saying is "don't expect me to clutter up my decision with the truth." Is Public Law 91-752 providing funding for the IUD? What is the societal impact of 91-572's program? Are you as willing to dispense with the truths of science as Justice Harnett is, Senator Cranston?

Another point at issue was whether or not the New York State Legislature was serious when it amended its State family planning law by calling the bill back off the floor and reprinting it to include the restriction limiting funding to only "the prevention of pregnancy." "His (Short's) interpretation of Social Services Law No. 131E (which)

mandated "family planning services for the prevention of pregnancy" as implicitly prohibiting abortion referral has no basis." I detect quite a contradiction, do you not? What is your position on tax-funded abortion referrals? The same as Harnett's quote above?

The third item under consideration by Justice Harnett was the effect in Nassau County of New York Court of Appeal's ruling on February 10, 1972, which prohibited use of Medicaid for elective abortions and which upheld the traditional and orthodox concept that Medicaid existed to provide the needy with life saving and life supporting medically indicated services. The court of appeals ruling was being ignored by Nassau County and abortion and abortifacient business continued to be financed through Medicaid. Working his way out of this one took a little doing by Judge Harnett.

Exhibits used at my administrative hearing relating to this issue were tampered with by the county between the time of the initial hearing and the appeal. Despite my lawyer's objection, the appeal was held without the exhibits which were relative to elective induced abortions and which had been fraudulently listed as therapeutic by the county and charged to Medicaid funds in violation of the Court of Appeal's ruling, and which have now disappeared from the package.

Photostatic copies of similar claims are now in the possessions of Nassau County District Attorney's Office, and he has decided not to prosecute in the hope that the *Klein* case will reverse traditional opinion that Medicaid exists for only life saving and life supporting medical services and the fraud committed by the population manipulators will be forgotten by everyone.

Justice Harnett in ruling against me, cited the *Klein* case now before the Supreme Court, an action brought after my dismissal, as justification for my dismissal. Our legal system prior to that decision has always held that a person may be found innocent for refusing to obey an illegal law but this is the first and only case I think any of us have ever heard where a person has been found guilty for acting within the requirements of the law in effect at the time of his action. For this Justice Harnett deserves a second Pulitzer Prize in science fiction. He also opened up another question with his reference to the right of election, or the right to choose. In the right to choose, where does the choice end? Does the choice end in the decision to engage in marital relations or not? Does the choice end with the decision to demand tax-financed artificial means to frustrate the natural end to such relations? Does the choice end with the demand for tax money for elective abortions? Does the choice end with the State mandating abortion and using tax money to accomplish that end? Where does the choice personally end with you? On what do you base your decision Senator Cranston?

Senator CRANSTON. Mr. Short, I regret another roll call. I think this will be the last one for a while. We will recess for a short time. Thank you.

[Whereupon, a brief recess was taken.]

Senator CRANSTON. The hearing will now resume. I am happy to report that is probably the last roll call. If you will proceed.

Mr. SHORT. I keep using your name quite often and I intend the questions for you personally and anyone and everyone who reads this record, to answer these questions in conscience before voting on this bill.

I expressed my view that there was no question but that the couple had the right to choose whether to have relations or not, but as to tax supported contraception or sterilization, while I acknowledge that some of these costs were at the moment considered legal, they were nevertheless unconstitutional, for the bill providing such funding constituted legislation in an area in which the State was proscribed from legislating, violating a person's right to privacy, violating the principle of the separation of church and State and violating the individuals right to freely exercise a right conscience in the application of religious beliefs and violated his right to exercise parental rights to control the moral upbringing of his family free from government or commercial coercion or interference. As to abortion I stated there was no question but that it was the unjust taking of an innocent human being's life. Justice Harnett's finding concerning my right to exercise my conscience was—

The repeated charged references to "create life" and "destroy life" not contained anywhere in the social services statutes or regulations, and his (my) concluding statement that "someone in the county is intent on using my tax dollars to take the life of an unborn child" reflect indeed the intrusion of personal bias into official duties—there is clear evidence to support the conclusion that the petitioner was unable to accommodate his personal views to the duties of his employer.

I detect a bit of personal bias on the judge's part, do you not, Senator Cranston? What do you think of his statement? What are the duties of an employee in the area of abortion, contraception, sterilization? Can you legislate in the area of contraception, an area of religious belief and teaching that affects the most private life of the citizen? How do you equate Judge Harnett's decision to the professed concept of voluntarism?

My position is one of total opposition to all that bill 91-752 and similar bills propose. I believe that recent Supreme Court rulings prohibit tax-supported or mandated inquiry by the State into the private and personal religious beliefs and practices concerning marital relations and intentions toward procreation because it is an area in which the State lacks a basis for enactment of legislation, and further an area in which the State lacks a basis for authorizing inquiry and action, and further it is an area in which the State is actually proscribed from legislating. These Supreme Court rulings apply to and prohibit Public Law 91-572 and all other government-sponsored tax-supported programs in this area.

The U.S. Supreme Court decision rendered January 22, 1973, in the case of *Roe v. Wade* dealt with the subject of procreation and held that, prior to a new life beginning, the right tantamount to absolute privacy prevails, and that subsequent to a new life beginning this right to privacy becomes a qualified right, based on a compelling State interest. After establishing these principles, the court goes on to rule when and how that right to privacy is qualified.

The *Roe v. Wade* decision found that the State, in the interest of justice, has a compelling right "in protecting fetal life" so "as to proscribe abortion" once life has begun. Unfortunately, a question to which the law has yet to properly address itself.

The Court ruled that, all must recognize that the woman's right once the child's life has begun, is a "qualified right." Silence on the responsibilities and rights of man, all must recognize that since there

is nothing the father does to incur them at birth, they must commence from conception.

However, the Court held that in decisions going back as far as 1891 the Court has recognized that prior to new life coming into existence a right of personal privacy or zones of privacy hold and that these are applicable in the areas of marital rights and procreation, and furthermore such rights do exist under the Constitution.

The Court finds the roots of these rights in the first, fourth, fifth, and ninth amendments and in the concept of liberty guaranteed by the first section of the 14th amendment.

It further holds that these decisions make it clear that marital rights relating to procreation are personal rights, fundamental and implicit in the concept of ordered liberty, and protected by the guarantee of personal privacy.

It further states that the basic decision of one's life respecting procreation comes within the blessings of liberty found in the preamble of the Constitution and that this right is so fundamental that, in order to support legislative action, the statute must be narrowly and precisely drawn and that a compelling State interest must be shown in order to remove these rights such as protection of parental rights.

Further, the Court holds that the freedom of personal choice in marriage, family life and procreation is one of the liberties protected by the due process clause and must be free from unwarranted governmental intrusion.

Finally, the right of privacy was held to be above rational inquiry, was held to be the right to be left alone, the right that in a constitution of free people the meaning of liberty must be broad indeed, and that the Constitution did not even permit Congress, let alone the State, the general power to inquire into the private affairs of a citizen and the right to privacy in matters of procreation is guaranteed absolutely against deprivation, as the State lacks a compelling interest to make inquiry into the area of marital relations and procreation. (U.S. Supreme Court 70-18 *Roe v. Wade* Jan. 22, 1973.)

I suggest you and every member of the committee and everyone who is going to vote on the bill read those decisions and see if you are not establishing unconstitutional law.

However, section 131-e of New York State's social service law, effective July 1, 1971, unconstitutionally mandates inquiry into the private and personal religious beliefs and practices concerning marital relations and procreation and as other Federal legislation such as Public Law 91-572 unconstitutionally uses tax dollars in a manner and in an area the Supreme Court just ruled the Government is proscribed from legislating.

As to when, how, and why a recipient engages in the marriage act, married couples rightly hold they have a constitutionally protected absolute right to privacy as to any decision that the father makes to beget children and his wife as the mother makes to bear children. Any mandated discussion, orientation, or inquiry as to whether or not they desire so-called family-planning services is an unwarranted and unconstitutional interference into their private lives because the answer to that question requires an answer to, and reveals, when, how, and why they engage in the marriage act, and further such so-called tax-supported, family-planning services violates the separation of church and State and is an improper use of tax moneys.

The integrity of marriage and the family unit must be maintained and not usurped by some "new speak" redefinition of the role of government. After a new life comes into existence the role of government comes into play. That role is the promotion and protection of justice. Since nothing can be more unjust than the taking of an innocent person's life at any stage of development, I oppose abortion, oppose its legalization, oppose the use of my tax dollars to support it and favor a government guarantee of the right to life, such as that proposed by Congressman Hogan.

Prior to a new life coming into existence, marriage and the family unit are concerned with questions pertaining to marital relations and the generation of life and love—private questions answered by a right conscience in application of a person's personal religious beliefs. These areas are a province of the individual's church and not the state. I agree wholeheartedly with the Supreme Court's upholding this zone of privacy prior to the new life coming into existence, and wholeheartedly oppose any Government regulation other than protection of parental rights in the area of contraception and sterilization as it is on its face unconstitutional, and is an invasion of the right of privacy and is in violation of the principle of separation of church and state.

Thank you.

I would like the committee's answers on their consideration of these questions.

Senator CRANSTON. Thank you very much. I assure you, that the question proposed will be very carefully considered.

We can proceed with the hearing.

I understand Mrs. Golden will be the next witness.

STATEMENT OF MRS. CATHERINE GOLDEN, MEMBER, NEW YORK STATE'S RIGHT TO LIFE COMMITTEE, TROY, N.Y.

Mrs. GOLDEN. My name is Catherine Golden from Troy, N.Y. Thank you for giving me the opportunity to speak today.

I will concentrate on three aspects which are of particular interest to me.

First, as a woman and mother.

Second, as an elected member and vice president of the enlarged school district of the city of Troy, N.Y.

Third, as a member of New York State's Right to Life Committee.

I speak first as a woman and mother because this bill is obviously aimed most directly at us—women, mothers of families.

May I begin by saying thank you, as a woman and a mother, for being invited to speak. Certainly a program so all-encompassing as the one you are considering today should have a good deal of input from those of us most affected. So I would first recommend that every step along the way women and mothers be consulted, not only because of the programs' obvious effects on us, but because in addition to giving birth and life to the future, we can often be counted on to give life and truth to the present.

Therefore, I urge that active consideration be given to research in natural, drugless family planning methods that will not require surgical manipulation of people's bodies, will not require making women feel that their bodies are constantly vehicles to be manipulated or that they are solely the ones responsible for family planning.

Our society needs some cheap, safe, easy to understand family planning methods which are responsive: (1) to the concept of human dignity as understood by men and women in our country; (2) to the traditions and sensibilities of black, Hispanic, Indian American and other minority groups; (3) to the conscience of the millions of Catholics, Mormons, and other religious groups who do not believe in artificial, chemical and mechanical means of limiting or planning families. Not everybody has the same body chemistry. You are all aware of the many "beware" and "do not take" and "cannot be used by" warnings which appear on our present contraceptives.

There is a vast group of us women, who because of our culture, our religious beliefs, our body chemistry or our husbands, will not, cannot, do not use the methods most promoted in women's magazines and in the majority of planning programs now in use, that is, chemical, mechanical, artificial methods.

A top priority, then, is research in methods suitable to this large group of women. Particularly, since one of the major experts in the field, Dr. Christopher Tietze, associate director, biomedical division, the Population Council of New York has ranked one natural family method, temperature rhythm, in group A as highly effective and equal in effectiveness to the much-touted pill. (Sobrero, Aquiles J. M.D. and Harvey, Rosalie M. (eds.) *Advances in Planned Parenthood*, volume VI, proceedings of the eighth annual meeting of the American Association of Planned Parenthood Physicians. Boston, Mass., April 8-10, 1970. Amsterdam, N.Y., 1971).

Some may say this is an impossible dream—safe, suitable, natural family planning. Or that it is too difficult. A trip to the moon was once an impossible dream, yet this Government was able to do it. Polio, malaria, TB, measles, diphtheria once meant almost automatic death—but modern medicine has conquered them.

Time and time again we have proved that if Government and science set a priority, determine to put effort and money into a priority, solutions result.

I do not believe that we women should accept a pill which does strange and often terrifying things to our bodies, or an IUD which your experts will tell you is spontaneously rejected in hundreds of cases and utterly useless for thousands.

So my first priority as woman and mother then is: (1) Involve us in the process; (2) find a natural method which will suit our needs.

In May 1970, I was elected to the Troy, N.Y. School Board and made vice president in 1972. We serve a population of 70,000 in our city and daily attendance in our elementary and high schools runs about 6,000.

You are all aware that it is a great challenge to act, responsibly, on behalf of the electorate. Even at the school board level, we must be aware that each citizen is involved, as fully as possible, in the decision-making that will affect his and her life.

So I am particularly concerned, then for citizen participation, in family planning programs—and that these citizen groups (call them boards, or advisory councils, or whatever) be responsive and reflective of the society and community where they live.

Once you start talking about family planning education, then you are in my school, my home and my value system. It is impossible to

teach anything without projecting your own values or, as is so often unhappily the case, your no values system.

Unless carefully monitored and responsive, at every level, family planning could become the big brother that would override parental rights and responsibilities and make no distinction between information and propaganda.

Today population propaganda, and I can find no other word so suitable, often works against us mothers and fathers. Population propaganda has a tendency to equate the woman like a butterfly, dissect and destroy her role in creating human life and equate human sexuality and sexual experience with an amusement park.

So I urge that families be involved in family planning programs, not a peer oriented programming which treats sexuality as so much mechanical expertise.

To do this citizens at every level must be involved. Therefore I urge that either special citizens boards or already elected local units, such as town or county government or area or local school boards, be directly involved in reviewing, recommending, and monitoring these "information" programs.

I firmly believe in citizen participation. This hearing itself is evidence enough that you, Senator, believe in it also. But it is not in the bill as I read it—except at the national level with the advisory council who are to be consulted on a continuing and regular basis in the administering of this title.

This is excellent but it does not go far enough. Nor is it enough to offer "substantial opportunities" for "low income persons served" to participate in the decisionmaking process of such projects or programs." This could be a mere questionnaire being filled out by a recipient.

No programs of this nature will be different in urban areas, farm areas. There is already mounting complaint from those labeled by society as "poor" that their lives are being more and more controlled from above.

I know for a fact that our school board would resent strongly any attempt by federally funded experts to teach family planning in our schools, without consultation and involvement on our part. And I know further that the people of Troy, to whom I am responsible, would resent even the school board imposing some such program on them without the direct involvement of parents and teachers in the planning and programing.

So my second priority as an elected representative of the people of Troy, N.Y., charged with being responsible for public education for both children and adults in our community is to unequivocally state the absolute necessity of involving local groups in the planning and preparation of any educational materials either for use by adults or children in the area of family planning.

Finally there is section 1008. As a charter member of New York's Right to Life Organization, I am happy to see this statement in the bill:

None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.

I am pleased because as a woman, abortion to me is a horror. It is one of the easiest ways for men to get out of a problem. It is not a help

to women but a degrading, deadening, destructive act which treats women as a toy and their offspring as objects to be used if needed, destroyed if not.

With abortion we are building ourselves up for one mess of problems in the next generation due to the mass slaughter taking place now, particularly in New York, but soon all over the country.

More and more we hear that abortion is being promoted as a "backup to contraceptive failure."

Abortion is just another way of using women's bodies and as a woman I resent it as demeaning, degrading, defeating.

It defeats what this country is and what it stands for: dignity of the individual, responsibility for our acts, concern for the helpless.

I would urge then, that not only abortion, but all the aspects of the "abortion mentality" be excluded from any legislation: menstrual extraction, abortion counseling, human fetal experimentation, degradation of the poor, compulsory sterilization, to name a few.

The value of human life must be at the heart of any program of planning for human life, and family planning is exactly that. The family, whether large or small, should be looked upon as a plus for our society, particularly in a time when our Government statistics show our society is growing older and older.

The young, then, as always are our gift and participation in the future. And we must be very careful of how we treat them. We must also be aware that we do not become a society which determines by Government fiat who shall live and who shall die.

I fear that often those who are called "liberal" are the most "il-liberal" of all when they insist that only this number of people, this quality of people shall be permitted to live in our society.

I believe I am liberal when I want equality for all, rich and poor, educated and educable, black, white, brown, yellow, red or whatever.

A truly liberal program will take into account all these things and provide a positive, value-oriented vision for the future.

Millions of us who share these concepts are well used to what has often become a less than honest reaction to our beliefs and views: the subtle snicker, the pessimistic sneer, the wry and patronizing grin, the shouting outcry that screams "you do not know what you are talking about," and then proceeds to action completely ignoring the existence, not to mention the concerns, of people who are deeply committed to their values.

It seems to me that in considering family planning and population in general, issues so intimately connected with individual people, and affecting the future of all those individuals and now nameless individuals still to come, or not to come, that all aspects of the sensitive matter must be considered. Especially must all sides be considered when Government money, provided by all the people, is the background making any action programs in family planning and population science possible.

Sometimes the difficult questions which are sidetracked because they demand too much money or time—things like an effective and natural family planning method or the belief that ordinary people are capable of considering and keeping in mind not only their own future but those of their fellows and of acting accordingly—sometimes these difficult questions have solutions so near and so simple that they are

overlooked. Yet, let us not overlook the possibility that these very solutions may, in fact, be those which distinguish people with dignity and freedom, the kind of people our Nation professes to serve, from those without it.

I am one of those who believes this very strongly. And like millions of others of similar beliefs, I am not willing to settle for the subtle snicker, the pessimistic sneer, the wry and patronizing grin, the impolite scream down. I want action that will respond to the needs of American men, and women all across this land. I would look for hard work, for complete scientific open mindedness in any Government programs pertaining to family planning and population science.

The best is the only thing good enough. We demand it. We can settle for nothing less. And you can believe that I and others like me are aware and will insist on participation every step of the way. Thank you.

Senator CRANSTON. Thank you, very, very much, Mrs. Golden. We will now hear from Mrs. Terry Siller, secretary, Nassau County Chapter, New York, Women for the Unborn.

STATEMENT OF MRS. THERESE D. SILLER, SECRETARY, NASSAU COUNTY CHAPTER, WOMEN FOR THE UNBORN

Mrs. SILLER. My name is Therese Siller, and I am here today representing Women for the Unborn. I would like to begin by expressing my appreciation to the committee for giving our organization the opportunity to testify.

I wish to preface my remarks by stating that due to short notice of this hearing, I was unable to distribute my testimony to the members of Women for the Unborn. However, I proceed believing that my statement will represent the sentiments of the nucleus of our organization.

In all the time allotted to me today, I thought I would focus on one question. It is a question that came to me as I read Senator Cranston's opening remarks in the Congressional Record of Thursday, May 3, 1973:

"* * * the original passage of the Family Planning Services and Population Research Act of 1970 (Public Law 91-572) was the culmination of years of effort on the part of many groups and individuals to make family planning services available to all those who wanted but could not afford them, as well as to improve our knowledge in the field of human reproduction and population dynamics so that each individual family could determine its size by choice rather than by force of circumstances."

Later in his statement, Senator Cranston says:

"* * * to date, we have not made enough headway in the research field. Today there is as yet no completely safe and effective means of contraception available to any woman, rich or poor. Research is urgently needed to develop a means of voluntary control of reproduction. There is much scientific opinion that the technology is there to make this breakthrough if adequate funding is provided."

In addition, Mr. Cranston refers in several places to the "women who want family planning services, but are unable to afford them."

These statements pose considerable confusion to me in view of the information now available on Dr. John Billings' ovulation method of regulating the size of one's family. The ovulation method is the break-

through for which we have been hoping. Utterly safe and effective, completely natural, the ovulation method is the means that can give "each individual family" the freedom to "determine its size by choice rather than by force of circumstances."

The expressed need for large budgets to educate women for family planning no longer really exists. The ovulation method is simple, needs no complicated instructions, and could easily be explained to the public through existing agencies and media.

It seems to me that the risky business of promoting artificial means of contraception should cease completely at this point. The pill, coil, etc., must not be administered to women, regardless of their effects on a woman's physical and psychological health.

The final paragraph of bill, S. 1708, reads as follows:

"Such grants or contracts shall, wherever feasible, include provision and funding for consideration of the relation of population to the total human environment."

One student of ecology put it—just as pesticides can break down the environment by killing fish and aquatic plants, so can birth-control instruments break down the environment by causing harmful physical and psychological effects in women.

Have we forgotten that we humans are part of nature? That we too must conform in harmony to natural laws? Or destroy ourselves in our defiance?

To continue spending exorbitant amounts of taxpayers' moneys to promote artificial contraceptive devices while we supposedly seek something that is already found, would be a farce and a scandal at this time.

It reminds me of something that Malcolm Muggeridge, the well-known English journalist and social critic, once said:

"*** when I was young, people used to say the poor had too many children. Or, at the time of the famine in Ireland, they would say that the Irish had too many children. We were taking the food from Ireland, and the Irish were starving, and we said they were starving because they had too many children. Now we who are sated, who have to adopt the most extravagant and ridiculous devices to consume what we produce, while watching whole, vast populations getting hungrier and hungrier, overcome our feelings of guilt by persuading ourselves that these others are too numerous, have too many children. They ask for bread and we give them contraceptives! In future history books it will be said, and it will be a very ignoble entry, that just at the moment in our history when we, through our scientific and technical ingenuity, could produce virtually as much food as we wanted to, just when we were opening up and exploring the universe, we set up a great whimpering and wailing, and said there were too many people in the world."

Might we add to the remarks of Mr. Muggeridge, that just at the moment in our history when our scientific and technical ingenuity provided the solution to the problem of family planning, we failed to recognize that solution when it was presented to us?

If this is possible, it could be only so as the result of a strange malady that is sometimes called "tunnel vision"—a common symptom of too much specialization. (that specialization that is one of our strengths but is also one of our weaknesses.)

(Perhaps, now we will set up a commission to study "tunnel vision." That would be fine, for the correction of "tunnel vision" is true perspective and proper proportion, and to achieve true perspective and proper proportion, the end and the means would be the same: new channels of communication that would bring people together in a personal way to exchange maximum information with maximum honesty for the benefit of all people in every community.)

Returning to my subject, I trust that we will not fall into this trap—this "tunnel vision." I hope that Dr. John Billings who has researched the ovulation method, has already appeared before this committee, or if he has not, that he certainly will be invited to do so. I brought with me today a copy of Dr. Billings book, "The Ovulation Method," American edition, copyrighted in 1972. I wish to submit it as my full testimony toward which this statement is directed.

In conclusion, let me quote the pertinent words of Gilbert Chesterton, which seem pertinent at this time:

"Let us assume that there are 10 little boys whom you wish to provide with top hats and you find that there are 8 top hats. To a simple mind it would seem not impossible to make two more hats; to find out whose business it is to make hats; to punish anybody who has promised hats and failed to provide hats. The modern mind says that if we only cut off the heads of two of the little boys they will not want hats and then the hats will exactly go around."

May God grant us that simplicity of mind that will provide us with the vision to make enough hats in lieu of cutting off heads—and may we always strive to use our science and technology to advance the cause of freedom and truth in love and harmony—a true family plan for the family of man on this earth.

I thank you again for your kind invitation to appear, and for every courtesy you have shown to me. I also wish to acknowledge the courtesy of Mr. Weiss in Congressman Lent's office in Baldwin, Long Island. Thanks to his cooperation, I was able to secure a copy of the proposed bill, S. 1708 in time to study it carefully. Thank you.

Senator CRANSTON. Thank you very, very much for that testimony that I know is very deeply felt by you. In regard to your request that the book by Dr. Billings be in the record, may we receive the book for the committee files and make it available to all members of the committee without necessarily printing it? The only problem is the cost, and I am not sure how long it is. We have some limitations on how much we are able to print in the record.

Mrs. SILLER. I would probably be more correct in calling it a booklet.

Senator CRANSTON. How many pages?

Mrs. SILLER. A hundred pages.

Senator CRANSTON. Could you designate the portions that you were most interested in having in the record, and we certainly could include those subsequent to your testimony.

Mrs. SILLER. I could do that, but I would have to check it first.

Senator CRANSTON. I would appreciate it if you would do that. But we will have the entire book available for study then by our committee members.

Mrs. SILLER. I can indicate the portions of the book that I would like to make part of my testimony.

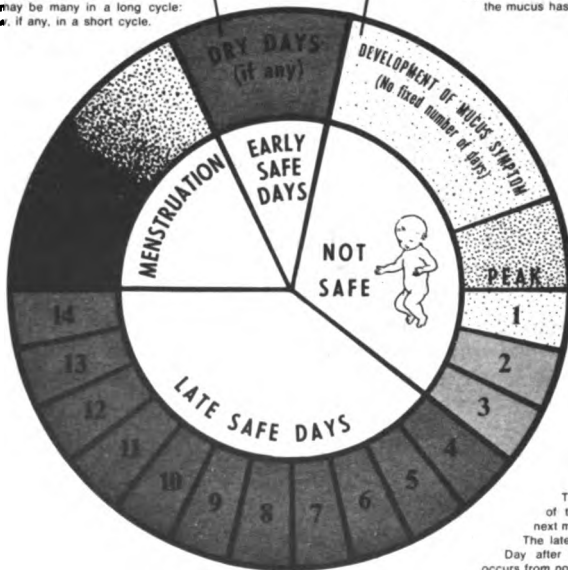
[The information referred to, subsequently supplied for the record, follows:]

THE OVULATION METHOD

This chart is to help pick the beginning of the mucus and to trace its progress. The cycle will not necessarily follow the exact pattern or length of days indicated here. The illustration is merely a guide.

A sensation or feeling of dryness around the genital area. The number of such days may vary in each cycle. They may be many in a long cycle, but few, if any, in a short cycle.

The end of the dry sensation means that the mucus has begun. If no dry days occur following menstruation the mucus has already begun.



(The mucus prolongs the life of the sperm cells. Conception may occur from any sexual contact on mucus days prior to ovulation.)

Clear, slippery mucus resembling raw egg-white occurs for a day or two at the peak of the symptom, and produces a definite lubricative sensation. The last day of this sensation is marked as the Peak.

OVULATION FOLLOWS PEAK

Days 1, 2 and 3 after the Peak are not safe.

The length of time between the Peak of the mucus and the onset of the next menstruation is about two weeks. The late safe days begin on the 4th Day after the Peak. If any mucus occurs from now on, it will be cloudy.

**A NATURAL METHOD OF ACHIEVING OR AVOIDING PREGNANCY,
WHICH IS HARMLESS, RELIABLE AND MORALLY ACCEPTABLE.
NO MEDICATION OF ANY KIND IS NECESSARY.**

1.

Additions To Be Added to the Testimony of Therese D. Siller

Following are excerpts from "The Ovulation Method" by Dr. John Billings, selected by me at the suggestion of Senator Cranston. While most of this material consists of direct quotations from the book, I would, in some cases, like to summarize his thoughts in my own words.

With the excerpts and my commentary, I include a special article, "A Trial Of The Ovulation Method Of Family Planning In Tonga" better known as the "Tonga Report." It describes the successful results of the ovulation method in a comparatively primitive society in Asia. I leave to the discretion of the Committee whether to include the Report here with my Testimony, or, if space does not allow, to place it in the reference file along with Dr. Billings' book. Requests for reprints of the report can be addressed to J. J. B., St. Vincent's Hospital, Victoria Parade, Melbourne 3065, Australia.

In his opening chapter, Dr. Billings places his discussion of the Ovulation Method in a cultural context. He discusses serious reasons for using only natural means of regulating birth, emphasizing a married couple's relationship to God, our Creator, and their need to "... maintain their close collaboration with God by never frustrating the creative power which may exist within the act (of intercourse) at any particular time." (p. 14)

Because we have a mixture of so many different cultures in our country, I am afraid that people with different backgrounds may communicate their understanding of our "Creator" or "God" in different terms, and thereby may fail to grasp the significance of Dr. Billings' viewpoint.

Hoping that I am not being presumptuous, and anxious to have the doctor understood by people from other cultures than his own, I would like to comment briefly on his opening chapter.

The science of cybernetics tells us that the human mind can only perceive what the imagination can conceive. Unless we can get a mental picture of an idea, we may not easily grasp that idea. In a discussion of "God", an invisible or spiritual idea, how is it possible to create a mental picture or image? How can we see with our mind's eye what we cannot see with our bodily eyes? One way that has helped me as it has others, is the use of symbols, analogies, etc. that can enable us to *relate* the unfamiliar to the familiar.

Why is this important? In this age of mass advertising, we all are aware of the power of the *image* — the mental picture that we have of a given person or thing. *Images* are used to sell products, to sell politicians, to sell ideas. However, it is good for us to remember that our *imaginings* can be tricky things. They can fool us. They can delude us by creating false images in our minds. Many believe, and I would agree with them, that this has been one of the primary reasons why the idea of abortion-on-demand has been successfully sold in our country. The terminology that is used in discussions on abortion does not create a clear mental picture or image of the reality of abortion. The "products of conception" does

not bring to mind a picture of a "baby". The "termination of pregnancy" does not create a mental picture of violent destruction to a tiny human life. A "fetus" often brings to mind a blob of tissue, some blood and cells. "Fetus" is a Latin word, as are many medical terms, and translated, it simply means "young one" or "offspring". However, the layman who neither knows this, nor sees the baby hidden in the womb, can be fooled – so seriously fooled that today we have legalized an act which might repulse many people had they a clear mental picture of the reality of "abortion".

With this in mind, please allow me to share the insights that help me to bring my mental images into focus.

Dr. Billings begins his book by speaking about "God" and our relationship to Him. However, in our society today, many will say that they no longer believe in a living "God", and may dismiss and reject without deep thought, the most serious reasons for the use of natural methods of birth regulation.

"God?" some say. "No – I don't believe in God." But a "Life Force"? Yes! A "Creative Energy"? Yes! "Love"? Yes! A "Creative Potential"? ~~Is~~ a "Power for Goodness"? Yes!

Let us remember that all of these are valid words for expressing the same idea. All of these are other names for "God". Which ever is our choice, let us understand that the life-giving force or energy that *animates* all of creation including humans, is the generating power that some call "God" – the power that all of us depend upon to sustain our lives.

Although I have never spoken to Dr. Billings, I believe that this is what he wishes to convey when he refers to "close collaboration with God". "Life-giving energy" – "Humanizing Love" – are other names for "God" – the All in All.

Think of electricity. Electricity is everywhere even though it is not always visible. But electricity can be harnessed, and in so being, it can be made "visible". We can see its power, feel its heat, see and feel its light. It can be carried into my house in a container – in a 220 line. Inside my house, it demonstrates itself. It "lights up" as it were, in countless ways – in my electric lights, in my radio, in my television – in my toaster, in my dishwasher, in my vacuum cleaner – in my stove, in my refrigerator, in my furnace. We may not see the electricity itself, but we know that it is present because we "see" the power, the heat, the light that it generates.

"God" is like that. Like electricity, "God", the Life force, is everywhere. As spirit, we can not see God because spirit is invisible. But spirit manifests itself, demonstrates itself, "lights up" as it were, in each and every person – in human containers – in John, in Mary, in Joseph. Just as electricity flows into, lights up, and animates my appliances, the Life Force flows into, lights up and animates us. Just as each different appliance demonstrates a different aspect of electricity – its power, heat, and light – each human "appliance" or "instrument" demonstrates a different aspect of the spirit of Life – God's power, his love, his light or intelligence. Depending on the body to which "Life" is fused, a different creative power or talent is demonstrated.

3.

Think of a rainbow. Light as energy is not matter. But fused to and crystallized through a any drop of water, light reveals its "parts". All the colors of the rainbow become evident. Light *materializes* and takes on^o parts.* Think of sunlight shining on a field of crusted snow. Think of stars twinkling in a velvet sky. Light demonstrates itself. It glistens. It sparkles. *Just as every star lights the sky by night, we light the earth 'by day'.

The symbols that we can use are endless, for all of creation is a projection and reflection of "Light" which is still another name for "God", — the "Light of the world". However, unless we "see" with our mind's eye that body and spirit are fused or united — that the Life is in the spirit — that the spirit is animating the body — we may never seriously ponder what our relationship is to that "animating force".

One of my daughters once had a severe toothache. When she went to the dentist, his first examination baffled him because her tooth looked perfect on the outside. After X-Rays, however, he discovered the source of the problem. At the time of its formation, the top surfaces of the tooth had never quite fused. At the very center, where the points of the crown should unite and fuse, a minute, almost infinitesimally small hole had allowed particles of food to enter. As a result, the inside of her tooth was completely decayed — close to exposing the nerve.

It seems to me that we run a similar risk. If union or fusion of body and spirit are not recognized, the lack of that very small link could cause widespread decay in our society. By using our freedom to destroy life or block the Creative Power from creating life, we can diminish the overall creative force and change the balanced tension that should exist in our world. Each of our actions affect that tension for the spiritual forces that animate us run through each of us and all of creation like an invisible thread. To consider the laws of nature (the laws of "God") is to recognize our relationships to our Creator, our fellow man, ourselves, and all of nature. It would behoove us, I think, to ponder on those relationships, realizing that each of us as a part of the whole ~~is~~ ^{all of us are} dependent and inter-dependent. Distinct and unique because our bodies are as different as the appliances in my home, we nevertheless, are dependent on each other's creative use of power and freedom. If more and more of us abuse that freedom, use our power to diminish creative love (God) — shut out the energizing Light and humanizing Love that is available to us, how very dark our world shall be.

It is my sincere hope and prayer that we in America shall strive in every way to polarize — to bring into one line — the light of science and the light of faith, for ^{the} ~~our~~ spiritual environment of faith can not long be isolated from ^{the} ~~our~~ physical environment of science. Should science or religion move separately, one apart from the other — each would most certainly become irrelevant and dehumanizing, for each would fail to consider the whole man, body and spirit — the needs of a starving spirit as well as the needs of a starving body. One author put it better than I can when he said, "Not to know what an angel is is a misfortune; not to know what a man is threatens sanity." (Frank Sheed in "Theology and Sanity"; Sheed & Ward, 1946)

Excerpts from "The Ovulation Method"
by Dr. John Billings

"The natural method of the regulation of birth depends upon the biological fact that women are at most times infertile throughout the whole period of their reproductive lives. Fertile days, when conception is possible, are less numerous than the days of infertility when it is impossible for an act of intercourse to cause conception. (p. 24)

"Fertility depends upon ovulation and the time of ovulation determines the disposition of the fertile and infertile days of each menstrual cycle. The Ovulation Method is so called to direct attention to the basic fact that success in the use of a natural method depends upon the recognition of the approach of ovulation and of the occurrence of ovulation; this will always be so whatever technique is used for this recognition of ovulation. (p. 24)

"The Ovulation Method does not require the administration of drugs, it does not require regularity of ovulation nor regularity of the menstrual cycles, and it is universally applicable. (p. 24)

"The essential ingredient of the Ovulation Method is the study of the cervical mucus pattern." (p. 24) "Every time a woman ovulates she will have a recognisable mucus pattern." (p. 25)

"In a menstrual cycle of average length, the woman observes no vaginal loss for a variable number of days after the period has ended; these are the "dry days". The interior of the vagina is always moist, but if there is no loss of any kind the external parts will be dry, and this *sensation* of dryness is able to be appreciated. The commencement of the mucus is recognized by the disappearance of the sensation of dryness. Within a day or two the amount of mucus increases, so that it now becomes visible, and the mucus proceeds to alter in its appearance and in the sensation it produces by its presence as the time of ovulation approaches. Close to ovulation, the mucus becomes clear and slippery, and stretches without breaking, (the Peak Symptom). (pp. 25-26)

"The 'Peak Symptom', the egg-white ovulatory mucus, is the most precise of the natural indications of the time of ovulation. The safe days after ovulation commence on the fourth day past the peak symptom. This peak symptom is the easy landmark in the cycle for all women." (p. 26)

(A) "mucus identification chart is a composite diagram which will help the woman to interpret her own symptom correctly. It illustrates the usual sequence to be observed, thus:

- (1) Following the cessation of the menstrual period there is no loss of any kind. These are the "dry days".
- (2) The mucus commences. Even if little mucus is present it is recognized by contrast with the dry days. In many cases, an obvious plug of yellow, white, or cloudy mucus is observed, of a rather claggy consistency.
- (3) The mucus becomes more transparent, like egg-white, with a smooth slippery character. It is also like egg-white in being stringy which means that it will stretch without breaking.

2.

As the peak of fertility is reached, the mucus develops a distinctly lubricative quality, which can be recognized even if the amount of mucus is too small to be seen.

(4) Following ovulation the mucus may again become cloudy, white or yellow and slightly uncomfortable from its tacky consistency, and may then cease altogether." (p. 36)

"Almost all women recognise the cervical mucus pattern after the first simple instruction. The remainder will learn to avail themselves of the information provided by the mucus, if they will keep a daily record of the observations for one or two cycles . . . simple observations which every woman can make after a little instruction, especially instruction by another woman." (p. 25)

"There are percentages published and circulated, particularly by the purveyors of contraceptive drugs and devices, concerning the unreliability of the safe period as a method of regulation of births. The so-called "failures" never seem to be studied to determine why the breakdown occurred. There is no statement in many cases as to the method the couple were using. If it were the Rhythm Method, for example, it is not made clear whether the formula the couple followed corresponded to the cyclic variations, or indeed whether they were using a medical formula at all. There are no questions asked whether there may have been intimate sexual contact during the fertile days, whether acts of interrupted intercourse may have occurred, or intercourse using artificial contraceptives; yet in any of these ways conception could have occurred. Furthermore, the advice of the doctors themselves is never queried, although in this field it may be wide of the mark. Sometimes, too, the doctor has given the correct information but the couple has misunderstood it. Many of the success-rate or failure-rate statistics given by persons who consider themselves experts on Family Planning, including the natural method, reveal that they do not even know the difference between the Rhythm Method, the Temperature Method and the Ovulation Method." (p. 62)

"The Rhythm Method is fundamentally different from the Ovulation Method, because the Rhythm Method studied the dates of the menstrual periods, and, by calculations based on the variations in the length of the menstrual cycles, attempted to predict the time of ovulation. The Temperature Method is better than the Rhythm Method because it does give information about the occurrence of ovulation and the end of the cycle. However, the Temperature Method gives no indication of fertility or infertility ahead of ovulation, so that on its own it is useless in anovular cycles, and only of little help when there is a long wait for ovulation to occur, e.g. after childbirth, in long, irregular cycles etc." (p. 24)

"The Ovulation Method eliminates the difficulties and weaknesses of both the Rhythm Method and the Temperature Method. It is not concerned with the length of menstrual cycles, nor their regularity, nor with counting days from the time of the period; it is concerned only with the current cycle, and determines each day, from the reliable natural indications, whether the day is infertile or possible fertile." (p. 24)

3.

"It is evident that if intercourse is avoided at and around the time of ovulation, conception cannot occur. . . (and) the successful application of the natural method depends upon one essential point. . . the time of ovulation . . ." (p. 20) "The detail of the Ovulation Method does not prove difficult to understand or remember; . . . most of it is mere commonsense." (p. 62)

" . . . many people are still pre-occupied with a search for a method of regulating the menstrual cycles or more particularly of regulating ovulation . . . By using a method of ovulation detection, such as the Ovulation Method, the problem of irregularity is disposed of; if ovulation can be identified, it makes no difference at all whether it occurs regularly or not." (pp. 62-63)

"It is a remarkable fact that the contraceptive pills once had the reputation of being able to overcome irregularity of the menstrual cycles. The reputation was entirely without foundation. The idea of regulating the cycles with the contraceptive pills was possible fostered by the regular "withdrawal bleeding" which is imposed on most women taking the pills in imitation of regular menstruation. Once the pills are discontinued and true menstruation returns, the cycles tend to exhibit their previous pattern. In some cases there has been even more marked irregularity than previously, or irregularity appears where there was none before. Not only does the Ovulation Method not require regularity of the cycles, but the application of the Ovulation Method is delayed by the use of the contraceptive pills, as they either suppress ovulation or mask its signs." (p. 63)

(In Chapter V, Dr. Billings outlines other fertility symptoms as well as the mucus symptoms, pp. 32-40, abdominal pain, inter-menstrual "bleeding" or "spotting", and bearing down pains.)

"There are various other indications of the chemical changes taking place at about the time of ovulation, e.g. greater energy, oiliness of the hair, a tendency of the wedding ring to stain the skin etc. Such symptoms may have value for individuals, but should be checked against the more certain indications of ovulation before being accepted.

"In some women sexual interest is more noticeable at about the time of ovulation, and may then be accepted as an additional useful indication of the fertile time. Increase in sexual inclination which is likely to have a chemical basis may also be noticed during infertile days as well, for example, towards the end of the menstrual period or about midway between ovulation and the next menstrual period; fluctuations in sexual desire cannot therefore be regarded as a reliable indication of fertility. One hears objection to the avoidance of intercourse at the fertile time on the ground that this prevents a display of affection at the most attractive time of the cycle. If this objection had much validity it would hold even more strongly against the contraceptive pills, because the pills not only deprive a woman of ovulation, but also lessen the normal hormonal chemical changes of ovulation which provide the physical basis of an increased desire for intercourse." (p. 40)

"In the early years of marriage, emotional adjustment may be assisted when a strong physical

inclination helps to overcome emotional shyness and reserve. It is not difficult to understand why an internal chemical stimulation of sexual interest should occur on the days of maximum fertility as well as at other times; in some marriages the combination of low fertility and infrequency of intercourse would result in childlessness unless some natural phenomenon promoted the occurrence of intercourse at the peak of fertility. As the partners mature in their love with the passing years and the growth of their family, the physical act of intercourse comes more and more to express and nourish the love of the husband and wife for each other, and the inclination for intercourse to be determined by the desire of each to serve the happiness of the other and the good of the family. Periodic restraint of the desire for physical self-gratification now not only intensifies the delight of intercourse subsequently, but makes the act more truly expressive of this unselfish love. A generous abstinence from intercourse for the sake of the other though desire be strong has a beneficial effect on the marriage, preserving, strengthening and deepening the conjugal love. In some marriages the refreshment provided by this self-denial is not merely beneficial, it is an indispensable condition for peace and happiness.

"Those persons who are experienced in marriage counselling may have already learned the wisdom of advising some married couples to avoid intercourse at the time of maximal physical inclination for the time being, in order that they can really learn to love and not be deceived into believing that a more superficial sexual excitement is the greatest happiness attainable. When the desire for physical union comes to be stimulated by the happiness of two people sharing their whole lives rather than by the woman's internal secretions, there exists an important prerequisite for the enjoyment of intercourse in the years beyond the menopause, when loving will have little hormonal support.

"A wise wife learns that her husband's fluctuations of desire for intercourse are often determined by her attractiveness and loving invitations, to which he will immediately respond. If she will make a little effort for him, he will respond just as much at one time as at another. With her anxiety relieved by the security of the "late safe days" provided by the Ovulation Method she and her husband can find delight in their love beyond any level that a hormonal peak could have helped her to enjoy. When the act is to express the conjugal love, little wonder that love should provide the inclination and that at the time of greatest love the greatest happiness is achieved." (pp. 40-41)

TEACHING THE OVULATION METHOD (p. 53)

"Experience has shown that women identify and teach the intimate and delicate details of the natural indications of fertility and infertility much better than do male doctors. Women who have developed the necessary confidence by using the Ovulation Method themselves, or supervising groups of other women using the Ovulation Method, are the best teachers of all, whether they have had any medical training or not. Not all women, of course, have the aptitude and enthusiasm to become good teachers, but there is tremendous scope for dissemination of the necessary information from one woman to another." (p. 53)

THE LANCET, OCTOBER 14, 1972

Special Article

A TRIAL OF THE OVULATION METHOD
OF FAMILY PLANNING IN TONGA

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Summary In the ovulation method the woman defines the fertile and infertile days of her menstrual cycle by interpreting the cervical-mucus pattern. Clinical studies have shown that in all women the occurrence of fertility is accompanied by a characteristic mucous secretion, which allows the woman to recognise the days when conception is likely. This information provides a "natural" method of family planning, and a trial of its potential value was undertaken in a Pacific Island community. The method proved to be both acceptable and successful. Altogether 282 women used the ovulation method for a total of 2503 months, with one case of method failure and two cases of user failure.

Introduction

THE ovulation method¹ was developed to overcome the weaknesses of the rhythm method and the temperature method. The ovulation method is based on the known association in animals and humans of a characteristic type of cervical mucus, and usually an actual mucous discharge, at about the time of ovulation; it involves the instruction of women in the accurate interpretation of a symptom with which they are already quite familiar. The ability of women to recognise this symptom has already been assessed.² We found that even unintelligent and uneducated women were able to use the method successfully, either to avoid or to achieve pregnancy.

Doubts have been expressed about the probable success of a method of family planning which demands periodic abstinence in a "primitive" community. An opportunity to undertake a trial of the method in Tonga presented itself in 1970 when M. C. W. visited Melbourne, after many years' experience as a teacher and a nurse in Tonga, during which time she had become fluent in the native tongue.

Tonga seemed to be a suitable area for a clinical trial of the ovulation method. The people are Polynesian, gentle, friendly, and easy-going in their outlook. Very few women are aware of the length of their menstrual cycles. The practice of coitus interruptus is common, there is a general lack of motivation to limit the family's size despite poverty, and a consequent tendency to resist the application of methods involving continuing supervision and personal effort, whatever claims for success are made in their promotion.

The total population of the Tongan Kingdom is about 90,000 people, scattered over a total of 150 islands which

cover an area of 250 square miles. The economy is wholly dependent upon agricultural products, and diet contains a large amount of carbohydrate. Only one person in five is gainfully employed, but most people have enough to eat. Primary-school education is compulsory and some medical services are free. European civilisation has made some impact on the inhabitants, but the majority are still rather unsophisticated, generally having difficulty in sustaining attempts at material advancement.

Instruction in family planning involved extensive travel around the islands by car, bicycle, and boat. In many areas only occasional visits were possible, separated by intervals of months. This necessitated taking up residence in various localities until a proper understanding of the method had been reached. The acceptance of the method was a voluntary decision made by both husband and wife. They were free to learn the method, to use it at once or later if they wished, and they were promised assistance whenever it was required, on the understanding that they would always be free to abandon the method and to return to it again.

The usual technique was to gather the women and their husbands together on a Sunday evening and to outline the method. The need for the couple's mutual cooperation in avoiding sexual contact when the mucus indicated possible fertility was emphasised. It has proved a considerable advantage to instruct the men, not only for the individual couple, but also because the men help to spread the information to other couples in their villages. People of "advanced cultures" have suggested that men living in more primitive communities will not tolerate sexual restraint. Our experience has shown this to be false, both by the ready acceptance of the husbands of a period of continence and by the abandonment of the habit of coitus interruptus in the vast majority instructed. There was strong male cooperation despite the relaxed life of the island, which would not be regarded as conducive to sexual restraint. The strong motivation of women who used the method successfully was partly the result of their husbands' insistence that they cooperate with the teacher.

On the following morning the women attended for more detailed instruction, when there was free discussion of the details of the mucus symptom. Some general instruction on anatomy and physiology was provided, with an explanation of ovulation and its occurrence approximately two weeks before the next menstrual period. It was explained that, unlike the rhythm method, the ovulation method does not require regular menstrual cycles, nor the keeping of a calendar. The phases of the menstrual cycle were outlined—the menstrual period, the "dry days", and the "mucus days". The change in the physical characteristics of the mucus close to ovulation was described in detail, the appearance of clear or stretchy or slippery mucus being the reliable indication of fertility. Emphasis was placed on both the appearance of the mucus and the lubricative sensation produced by this "fertile" mucus—the "peak" symptom which the women find easy to recognise. It was also explained that during long cycles, during breast-feeding, &c., "patches of mucus", that is, a succession of days on which mucus may be observed, occur intermittently before the typical pattern of a fertile ovulation, and that until the woman is experienced in the method sexual contact must be avoided whenever mucus is present. The scanty-mucus pattern of infertile cycles was also explained, and the need to distinguish the loss of seminal fluid after intercourse from the mucus symptom, an ability which is quickly attained.

A simple method of recording this information by the use of red, green, and white stamps was developed in Central America, and this was of great practical value. This record keeping, especially during the first few cycles after instruction, has the advantages of training the women

to understand the symptom and of providing the teacher with a record of the progress of the instruction. The women also helped one another by comparing and discussing individual records. In each locality the women were seen at least weekly, or more frequently if necessary, so that additional instruction could be given and confidence in the method gained.

Initial Response

In the first few months, when the teaching method was being developed, some women expressed difficulty in understanding the mucus symptom, a few complained of persistent vaginal discharges, and there were some reports of pregnancies which were interpreted as failures of the method until the areas involved were revisited and the circumstances in which these pregnancies had occurred determined. There was resistance in some cases to efforts to persuade the husband and wife to abandon the coitus interruptus which initially was practised by about 85% in those receiving instruction. A suggestion to use the thermometer was rejected because practical experience had shown that a large-scale use of the temperature method was impossible, both because of the expense involved and more especially because the method necessitates constant supervision. In addition, it was recognised that the temperature method is inferior to the ovulation method because it defines only days of infertility after ovulation, and even in that is less precise than the ovulation method. Tonga has its own special problem, in that prolonged breast-feeding is common and basal-temperature measurement cannot give warning of the resumption of ovulation. The temperature method also does not give information on infertility during anovulatory cycles.

It was essential to warn the husband and wife that coitus interruptus during the fertile phase of the cycle cannot be expected reliably to prevent pregnancy. Therefore, only those couples who were prepared to abandon the practice were accepted into the survey, there being no intention of allowing either the successful prevention of pregnancy by coitus interruptus to be recorded as a success for the ovulation method or a failure of coitus interruptus to be recorded as a failure of the ovulation method. Additionally, acts of sexual intercourse, including coitus interruptus, during the presence of the cervical mucus make the assessment of the symptom more difficult and therefore delay or prevent the correct interpretation of the symptom. The great majority of couples soon agreed to discontinue coitus interruptus, with a predictable increase in the physical and emotional satisfaction they derived from the act of intercourse.

Pathological vaginal discharges were seldom a problem. They can usually be treated successfully and in any event do not prevent the woman from recognising the time of fertility by the change produced in the pathological discharge by the characteristic mucus. In those women with a protracted mucus symptom additional detailed instruction was given to increase the freedom for intercourse by defining "relatively safe days" when "infertile" mucus was present and by avoiding sexual contact on any days when clear or stretchy or slippery mucus was observed; these individual problems lessened with

increasing experience on the part of the woman herself and of the teacher.

The Group Studied

We report 395 women who were instructed after the start of the project in July, 1970; the results were assessed in February, 1972.

There was a good response to the instruction. 331 couples opted for the ovulation method. Most women found the mucus symptom immediately recognisable, and were pleased by the simplicity of the method. Many reacted favourably because they preferred a "natural" method, some because of the psychological advantage of a solution which is obtained by mutual cooperation, and some because of the attitude of the teacher, which never contained any element of coercion. The possibility of the information being employed to help those women whose marriages had been infertile created additional interest, and of the total there were 18 women who were anxious to become pregnant. 46 couples elected to use another method to avoid pregnancy, including one case in which the woman discovered that she had been sterilised at the time of a previous caesarean operation. The preference expressed by these couples was as follows:

Method	Number
Coitus interruptus	27
I.U.C.B.	5
Contraception (unspecified)	9
Condom	2
Contraceptive medication	1
Rhythm method	1
Sterilisation (unvoluntary)	1

In the assessment of the results care was taken to make allowance for other influences which could have contributed to success. Coitus interruptus has already been mentioned. The ancient custom of a period of abstinence after childbirth has now fallen into disuse, intercourse being resumed after childbirth within an average of 5 to 6 weeks, this time being unaffected by a decision to suckle the child or not.

Many women were instructed during pregnancy or immediately after childbirth. In all cases the time on the method was not measured until at least six weeks after the confinement. If the mother was feeding the child herself the time was calculated from the date on which solid food was introduced into the weaning diet, however long after the confinement this proved to be. It is a matter of experience that a number of the Tongan women do become pregnant again whilst fully breast-feeding their infants, but as breast-feeding does reduce fertility ten women were eliminated from the total on this account; they are nevertheless established on the method, and none has become pregnant. 14 women were eliminated from the assessment because it was judged that they were close to the menopause; they were forty-three years of age or older, had irregular menstrual cycles and a scanty mucus symptom; they too have followed the method by avoiding intimate sexual contact on days when mucus has been observed, and none has become pregnant. There were retained in the series 17 women aged 41 to 45 years in whom there was no clinical evidence of approaching menopause; all the remaining

TABLE 1—TOTAL CASES FOR ANALYSIS OF RESULTS

	No.
Couples learning method to avoid pregnancy when desired	331
Anxious for more children at present	10
No recent information	1
Separated	4
Pregnant at initial interview	2
Still fully breast-feeding	10
Menopausal (age, irregular cycles, scanty mucus)	14
Total remaining	282

women were younger. There were 2 women who were discovered to have been already pregnant at the initial interview. One woman has been lost to follow-up. 18 couples decided that they would postpone use of the method until they had had more children. 4 couples were eliminated because of separation, 1 husband having died, 2 having travelled overseas to seek employment, and 1 woman having required protracted confinement in hospital for mental illness; even when this woman was allowed home she was obviously unwell, and intercourse occurred infrequently (see table 1).

We encourage couples learning the method to refrain from sexual contact during the first cycle after instruction, so that the woman's understanding of the mucus symptom is not hindered by the effects of sexual intercourse. This recommendation was not insisted upon and not followed by all couples. However, to avoid loading the statistics in favour of success by the elimination of "high-risk cases", the time has been counted from the start of instruction and all have been included. There were two cases of the women having been uncertain of the correct application of the method; in both these cases the error was understood after further explanation.

There were 28 couples who, after following the method carefully for several months, elected to abandon it because they were anxious to have more children. The prompt occurrence of pregnancy when intercourse occurs on a day of clear, stretchy or slippery "fertile mucus" increases the confidence that couples have already developed in the reliability of the method. All of these couples intend to use the method again after confinement, and some are already doing so.

There were 50 women who "took a chance" by having intercourse on a day when the presence of the mucus had been recognised, and who therefore had no difficulty in realising why pregnancy had occurred. All of these women except one, who finds the observation of the mucus symptom and the period of abstinence troublesome, intend to use the method again in the future and many are already doing so. There is

TABLE 2—ANALYSIS OF 81 PREGNANCIES

	No.
Couples using method	282
Subsequently pregnant	81
Abandoned method, desiring more children	28
Ignored indication of possible fertility	30
Used mucus day, thought infertile	2
Considered no days of possible fertility used	1
Average age (yr.) of women who deliberately or carelessly abandoned the method	33.2
Average number of children	4.8
Average age (yr.) of women still successfully applying the method	33.7
Average number of children	6.8

only one woman who believes that she did not have any sexual contact on a day in which the mucus warned her of possible fertility; she too, however, although apparently a "method-failure", is now using the method again, and successfully (see table 1).

Results

The pregnancies which occurred, other than by design or by the conscious neglect of the instructions, were classified in one of two ways:

A biological or method-failure was recorded when, so far as could be ascertained, the couple had understood and carried out the instructions faithfully.

A user failure was recorded when there was an error on the part of the couple which the teacher could ascertain and explain to them to their satisfaction.

Altogether in this series a total of 282 women used the ovulation method for a total of 2503 months. There were two cases of user failure and one case of method failure.

Of the 18 women who were anxious to conceive, 7 subsequently became pregnant after careful attention to the mucus symptom and concentrating acts of intercourse in that part of the cycle when the peak symptom was in evidence. Previous investigation has shown that this peak-symptom day when the mucus is clearer than at other times, when it is stringy and produces a definite lubricative sensation, is on the average 0.9 days before ovulation.¹ Knowing that it is necessary for the spermatozoa to be in the female genital tract for some hours in order for them to become capable of fertilising the ovum, the day of the peak symptom is taken as the day of maximum fertility.

One of the women classified as a user failure had a long cycle in which mucus was observed on a succession of days. She had then incorrectly concluded that she had passed ovulation and had intercourse later in the cycle, on a day when copious amounts of clear slippery mucus were present. Explicit instruction is now given regarding the possibility of recurrent days of mucus in long cycles, in order for this mistake to be avoided, with emphasis on the avoidance of sexual contact when a fertile type of mucus is observed.

The second woman classified as a user failure had reported some confusion about the instructions, and uncertainty regarding the definition of fertile and infertile days. This pregnancy miscarried in July, 1971, after which she recommenced the use of the ovulation method; when last seen in March, 1972, she had become quite confident, and was using the method successfully.

The woman who was classified as a "method-failure", because she was unaware of having used a day when any mucus was present, received her initial instruction immediately after a confinement, before ovulation and menstruation had recommenced. The child which was conceived after instruction was born in September, 1971, and since then the woman has been using the ovulation method successfully.

Discussion

There is in Tonga a Government-sponsored birth-control programme which provides contraceptive medication, intrauterine devices, &c., free. The interest of the people in the natural method is therefore

in spite of these other provisions. Approximately 75% of the women who came for instruction were Catholics.

Establishment on the method is accompanied by feelings of relief and freedom. Many women quickly determine to pass on the information about the method to other women, and in particular to instruct their daughters so that they, too, can space their families. It is essential that the method be taught by a woman who is devoted to the success of a natural method and that the teaching be kept quite separate from that of any other method of family planning. It is not essential that the teacher should have had medical training; most women learn to become competent teachers after charting and studying their own cycles for a few months. An essential point which is emphasised in the instruction is that the women study carefully the sensation produced by the presence of the mucus, as well as noting its appearance.

It assists understanding of the method when women are reminded that they may have infertile cycles from time to time, in which little mucus is evident, and that this does not prevent the successful application of the method. Many "infertile" women notice that the typical mucus occurs in very few cycles, or not at all; instruction will acquaint these women of their greatest chance of achieving pregnancy, and will provide the information in time for it to be applied.

In the early months of this project a number of difficulties had to be overcome and the teaching programme organised. There were a number of women who found the interpretation of the mucus symptom difficult at first, and there were cases where the husband and wife found the periodic abstinence a problem. As we have observed in other circumstances, the abstinence became less of a problem when confidence in the method was established and the practice of coitus interruptus eliminated.

This investigation has demonstrated that the ovulation method is capable of successful application

in a Pacific-Island community. The extraordinarily high success-rate is to be attributed to several factors:

(1) The teacher was a woman. She was an experienced teacher as well as a trained nurse, and most of the women instructed had been taught by her in their school days, so that she knew something of their character, ability, and dispositions.

(2) The teacher lived with the people during the learning period, so that she could provide individual advice and attention.

(3) The couples were living far from the pressures of modern civilisation. Possibly they have a greater awareness of physiological changes in the body than people in more sophisticated communities. The women were aware of the presence of the mucus and were able to recognise the peak symptom, contrary to the expectation of some people without experience of enlightened teaching of the method.

(4) Strong motivation on the part of the women came in many cases from the influence of their husbands, who insisted that their wives cooperate with the teacher.

It may be more difficult to achieve a similar degree of success in all communities, especially in those where sexual permissiveness is fashionable. Our experience in Tonga has shown that the method works. The explanation for failures is to be found in inadequate teaching or in a lack of cooperation and motivation by the persons concerned.

It has been most gratifying that those couples who "broke the rules" have, if anything, greater confidence in the method as a result, and have willingly returned to its use subsequently.

His Lordship, John H. Rodgers, Bishop of Tonga, met the expenses of this project, and we thank him for his consistent encouragement.

Requests for reprints should be addressed to J. J. B., St. Vincent's Hospital, Victoria Parade, Melbourne 3065, Australia.

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Senator CRANSTON. Yes.

I would like to say, Mrs. Golden, in regard to one thing you stated in your prepared statement referring to the involvement of potential recipients, you say "Nor is it enough to offer substantial opportunities for low-income persons served to participate in the decision-making process of such projects or programs. This could be a questionnaire being filled out by a recipient." I want to assure you that is not what we intend. We mean substantial involvement by recipients, and we will make it plain in the report that a mere questionnaire is not satisfactory.

Mrs. GOLDEN. One of the problems with the bill is that there are so many vagaries, you do not define what you mean by certain things that would be helpful. If you would define your terms, and outline your plans and proposals, instead of just referring to them as plans and proposals, if you define exactly what you mean and how it is carried through, it would be a help.

Senator CRANSTON. That is one of the useful aspects of a hearing like this, where we learn about points you feel are not clear. We will seek to clarify anything else that is ambiguous. If you have further thoughts about specific points, let us know and we will do our best to make plain what is meant and what is not meant.

Mrs. GOLDEN. Thank you.

Senator CRANSTON. Our next witness will be Dr. Mark Thoman, F.A.A.P., Chairman of Des Moines, Iowa, Right to Life.

STATEMENT OF MARK THOMAN, M.D., F.A.A.P. CHAIRMAN, DES MOINES, IOWA, RIGHT TO LIFE

Dr. THOMAN. Thank you, Senator, members of the press. My testimony is going to be short. I am here today as a member of the medical profession, who specializes in the care of children. I am a pediatrician. Today, however, I am also speaking as a concerned citizen for the apparent direction we seem to be going in our family planning.

In studying the bill before you, I have been pleased with many of the ideas it contains. But I am an idealist, and perhaps naive, and I worry somewhat about the control and administrative problems.

I personally believe that any family or person who voluntarily wishes family planning information should be provided with it and I can endorse the services suggested in many parts of the bill. In this positive sense and spirit, I would strongly urge this body to retain Section 1008, which specifically prohibits the use of funds and programs where abortion is a method of family planning. Many citizens are deeply concerned and disturbed about the wanton destruction of human life which is occurring in increasing frequency in our country since the Supreme Court decision of January 22. The right to abortion in practical terms means that American physicians may very well be required to perform a million abortions this year and 2 million next year, based on the experiences of Hungary and Japan with similar laws.

Many family planning organizations such as Planned Parenthood, which began as a positive force for helping people plan their families intelligently has unfortunately become a vehicle for funneling women through abortion mills.

This is not family planning at all, but rather simple destruction of life. Where is this leading? In this month's Prism, a magazine which I have in my hands which is the socioeconomic magazine of the American Medical Association, I read "No one should be thought of as a life until about 3 days after birth," suggesting that if someone is born deformed ". . . we can destroy them in the first 3 days before a birth certificate is given."

Later in the same article, this same physician states without reservation "Sacredness of life or anything like that is not relevant to my experience."

I realize the oath we take as physicians seems to him to be just so many words, but my concern is where is it going to stop?

Many family planning agencies receive funding which comes from the pockets of taxpayers, many of whom are violently opposed to abortion. Funding for these organizations should not be provided by taxpayers' moneys as long as these organizations continue to deal in abortion. Our Nation is seriously split on this subject, as you well know, and there is no indication that the people of our land wish to have their funds terminate life in the first few months of its existence.

So once again, may I restate my strong position in supporting much of this bill, and in any program which will educate our citizens and implement whatever family planning methods they may desire. However, in no way can abortion be considered as family planning. Let us emphasize the prevention of an unwanted pregnancy, rather than destruction of a human life.

Any organization working toward this end should be supported but when an organization or agency becomes primarily an abortion referral agency, it must not be allowed funds under this or any other bill. I guess what I am saying is, I am putting all my "eggs in one basket." Retain section 1008! Thank you, Senator.

Senator CRANSTON. Thank you very, very much. As I understand it, that completes the testimony from this panel. Since all the time allotted to the Right to Life point of view has not been consumed, if there are others present who would like briefly to testify from that vantage point before we proceed to a different set of witnesses from a different vantage point, we would welcome testimony from any such people.

Mrs. SILLER. I would like to ask a question. Mrs. Golden referred to your defining your terms. I would like to ask if you could at this time define what you mean by population dynamics. I find that rather ambiguous.

Senator CRANSTON. We will in the report language or some other way seek to provide an explanation of what that means. If you would let us know about any other portion of the bill that you feel should be given fuller explanation in the bill or report, we would be glad to do it.

Mrs. SILLER. You had mentioned being specific. That comes to my mind very pointedly.

I would also like to ask you a question regarding the booklet, the Ovulation Method by Dr. Billings. Should I check that out before I leave today?

Senator CRANSTON. You do not have to. You can do that and send it back to us, so you have time to do it carefully.

Mr. SHORT. Could I ask you one other question—

Senator CRANSTON. Generally let me say the definition of population dynamics, as I understand it, is that it is concerned with general fac-

tors that relate to population size, and population distribution, the whole general area of various effects of changes in population patterns and size. We are not talking obviously about the promotion of any particular point of view in that regard.

Mr. SHORT. The reason I was just called outside, one of the local television stations, Channel 7, said they were interested in the question I raised as to the constitutionality of any legislation violating the right of privacy, prior to new life coming into existence. They asked me did I get any commitment from the committee on whether or not there will be a position paper on the part of the committee that will explore this question before they take any action on the legislation.

I told them I do not know, but I would certainly be interested.

Senator CRANSTON. We get appropriate legal opinions on any matter where there is a question of legality, constitutionality, and so forth; and we will do that in regard to questions that are raised about the legislation.

Mr. SHORT. Having raised the question, could I get a copy of that legal opinion then, so I know on what ground the legislation was conceived?

Senator CRANSTON. The opinions that we get on such matters will be set forth in the committee record when that record is made available. Each witness will be sent a copy of the full hearing record.

Mrs. SILLER. Senator, I had mentioned in my testimony that I had hoped and did not really know if Dr. Billings will be invited to appear before this committee. Will there be any such opportunity? Because I personally believe that this is such an important breakthrough, that it is precisely the very thing your committee started out working to do. It seems unbelievable to me that somebody of his standing with the method that he has to offer being so simple and so acceptable to all, and so natural, it would seem very incongruous that he would not be invited to appear before you and give an expert opinion.

Senator CRANSTON. At your suggestion, we will communicate with him, and ask him to submit a written statement to the committee concerning the bill, so that we will have his specific views on the legislation before us.

Mrs. SILLER. As I see it, something as simple as this method could be promoted easily and quickly all over the country, and believe me, we all know there is a need. Wives and husbands, families of any religious belief would be grateful to know it. I stumbled over this last week, my feeling is, "why did I not hear about it? Why did I not know about it?" There is a communication lag in this country that is very serious.

Senator CRANSTON. We appreciate your drawing it to the committee's attention, and we will communicate with him at your suggestion.

I thank each of you very, very much.

We will now proceed to a panel of representatives of women's organizations. There will be two separate panels, as I understand it, unless you agree otherwise; and unless those of you agree otherwise the apportionment of time will be 9 minutes for each representative of the 10 organizations appearing.

I understand that you have changed your order of presenting testimony so proceed in your own way.

**STATEMENT OF MS. VIRGINIA MILLS, STAFF CONSULTANT, TASK
FORCE ON WOMEN, UNITED PRESBYTERIAN CHURCH IN THE
UNITED STATES**

Ms. MILLS. I am Virginia Mills, consultant for task forces on women, United Presbyterian Church in the United States, and an active lay member of that denomination. I am not just speaking for women's organizations; I am speaking for our official denominational position.

I appreciate the opportunity to appear before you today and to present briefly the concerns of the United Presbyterian Church and the United Presbyterian women in the areas of family planning and population, particularly as they relate to the bill S. 1708.

The United Presbyterian Church in the United States as recently as May of last year devoted some time in its 184th general assembly to the problems of worldwide population growth. We see a great need for policies which deal aggressively with these problems, while respecting the freedom of individuals and enhancing the possibilities for healthful and fulfilling lives for all persons born into this world.

In calling for the development of sound population policies, the United Presbyterian Church established three specific criteria against which such policies must be measured.

First, they must be just. Policies must treat all with fairness. By this we mean specifically (1) that policies urging reduction of family size must be directed equally to all persons, not singling out any group or set of people; (2) that individuals to be affected by policies, particularly minority communities, must share in policy development and in the planning and administration of programs within their communities; and (3) that policies urging limitation of family size must be accompanied by concrete programs providing information and services necessary "to enable the poor as well as the rich to have real freedom of choice" in determining family size.

The second criterion is that population policies cannot stand alone, but must be seen as an integral aspect of social reform. We cannot accept policies which tolerate threats to the security or survival of any individual—threats posed by starvation, sickness, discriminatory educational and economic structures, and desperate living conditions. Population policies must coincide with efforts to insure economic well-being, quality education, greatly improved health care, and a more equitable distribution of wealth and land.

The third criterion is that policies developed must serve the very basic value of freedom. The United Presbyterian statement defines freedom as the capacity, opportunity, and incentive to make reflective choices and to act on them, and asserts that:

God gives man and woman unique choices and powers to share in creating human life. Freedom is the primary basis of the responsible (planned) parenthood movement within the church.

It is in the context of a concern for justice, humane living conditions, and basic individual freedoms, that United Presbyterians call upon the Federal Government to do the following:

First, to provide the information, materials, and services needed so that all families are free to make responsible decisions in the realm of childbearing.

Second, to support greatly expanded research efforts in the areas of human reproduction and population dynamics.

Third, to strengthen those agencies and programs now working in these fields.

Fourth, to support the preparation and distribution of educational materials in the areas of human sexuality and population/environmental concerns.

In speaking of the need to strengthen programs, I want to say that we in the United Presbyterian Church are distressed at the low level of authorizations available in the past for implementation of existing programs. We are aware that lack of such funds not only results in the lack of basic family planning services for millions of women, but also diminishes the possibility of new and better contraceptives being developed.

This last part is particularly important, as it touches on the health of almost every woman of childbearing age. Many of the women I represent today can easily afford the services of a private physician in matters of contraception. But despite our economic prosperity, none of us has access to a contraceptive which is both highly effective and also entirely safe to use.

Many of us were stunned to read recently of a young woman who, at the age of 28, suffered a massive stroke that rendered her more than 90-percent aphasic. On the advice of her obstetrician, she is now engaged in a lawsuit charging that responsibility for her stroke lies with the manufacturer of the birth control pills she had been taking for 3 years. Now I realize that the proof is not yet in for this specific case. Yet all of us have read or known of similar tragedies, and no one in the scientific community would claim that birth control pills are definitely without uncomfortable and, too often, dangerous side effects.

The fact is that we simply do not know enough about the human reproductive process. We do not now have any contraceptive which is entirely safe, effective, and suitable to the various moral and esthetic desires of men and women. No one knows for sure how safe the pill is for any individual woman. The technical disadvantages of the pill and IUD have already been discussed here by others more expert than I. Others have also commented on how little we know about infertility, and have noted the possibility of basic research yielding much needed insights into its causes and possible cures. Today I only want to emphasize that, as a woman, I appreciate in a very personal way the need for continuing research in human reproduction and in the development of safe, effective contraceptives for both men and women.

In emphasizing the need for research in human reproduction. I do not mean to downplay the need for increased research also in related areas. United Presbyterians have called upon the Government to increase funding for research on population distribution and the effects of crowding, and on reproductive motivation and life-styles or values that affect population-related decisions, as well as on contraceptive development.

There are several specific points in S. 1708 which I would like to comment on for just a moment.

Our church has stated clearly that the U.S. Government should "refrain from legislation and policies which may imply a special concern for limiting the size of families of minority groups." We believe it is incumbent on the Federal Government and on the common society to insure the availability of family planning services and com-

prehensive health care to persons who cannot themselves afford private medical care. We would oppose strongly, however, any proposed measures which would limit family planning services to minority persons or welfare recipients. We recognize that, often factors other than simple income levels, particularly geographic inaccessibility, prevent women from obtaining services. Our goal is to insure availability of family planning information and services to all persons desiring them, regardless of economic status. I believe S. 1708 attempts to meet this goal.

We also believe strongly that Government programs should "support indigenous community leadership in developing their own ways of utilizing family planning resources." The provision of S. 1708 calling for inclusion of service recipients on a National Advisory Council (section 1009(e)) and the section requiring that substantial opportunities be provided for participation by service recipients in local programing (section 1006(c)) are consistent with this belief. We would urge inclusion of more than one service recipient on the Advisory Council and would hope that local programs would reflect substantially this principle of consumer participation in their development and administration.

Finally, we share the concerns of those sponsoring S. 1708 that family planning services be strictly voluntary in nature and that they occur within the context of programs of comprehensive health care. We believe such programs should also include special services to groups with high infant and maternal mortality rates, and sterilization when desired, as well as readily accessible contraceptive information and materials.

In closing let me say that the United Presbyterian Church has urged the Federal Government to place higher priority on research in human reproduction and population dynamics, and on family planning, comprehensive health, and educational programs which enable all persons to make responsible decisions in the area of childbearing. We deplore the low rate of funding appropriated for such programs in the past, and would encourage higher levels of authorization and appropriations in the coming years.

I believe that S. 1708 attempts to deal with this and related concerns of our church, and urge its passage by the U.S. Congress.

Thank you.

Senator CRANSTON. Thank you very, very much. Would you now proceed in whatever order you wish.

**STATEMENT OF DR. ELOISE MURRAY, ASSISTANT DIRECTOR,
AHEA INTERNATIONAL FAMILY PLANNING PROJECT, AMERICAN HOME ECONOMICS ASSOCIATION**

Dr. MURRAY. My name is Eloise Murray, and I am representing the American Home Economics Association.

Mr. Chairman, the American Home Economics Association is pleased to support the provisions of S. 1708, the Proposed Family Planning Services and Population Research Amendments of 1973. The assembly of delegates of the American Home Economics Association voted in 1972 to encourage national and international home economics leadership to support family planning programs based on

sound population policies which respect the rights of individuals recognizing cultural and religious differences. It is within the boundaries of this policy that we appear here today to support S. 1708, which authorizes funds for family planning.

The American Home Economics Association is a national professional organization of 50,000 members, both women and men, with affiliated organizations in all the 50 States, the District of Columbia, and Puerto Rico. Home economists work in many kinds of institutions and agencies, including elementary and secondary schools, colleges and universities, cooperative extension programs, health and welfare departments and agencies, and in private business. Our common concern is that of improving the quality of and standards of individual and family life through education.

The AHEA has recently established a center for the family to serve research, educational, and program and policy evaluation functions through bringing together from all disciplines knowledge and understanding relevant to the family. The center will devote its resources to learn what it takes to produce satisfying family living—what kinds of environment, life grouping, and education are most likely to produce healthy and productive individuals.

The involvement of home economists toward a solution of population problems is a major concern of the American Home Economics Association. In this connection we are now administering a program funded by the Agency for International Development designed to stimulate home economists in developing nations to (a) promote family planning through effective use of their regular professional contacts; (b) develop overall standards and training recommendations for the profession which include family planning; and (c) support participation by home economics organizations and groups in the development of national and local maternal child health and family planning programs. Activities to date have included an international conference here in the United States, country surveys in six developing nations, workshops in Taiwan, Panama, and Thailand and consultation visits in several other countries.

To home economists, family planning is a broad concept taking into account the rights of families to make their own choices, including the right to space child bearing and to plan family size compatible with family resources and goals. The purpose of family planning is to improve the quality of life for individuals and society.

The delivery of health and other social services to people who most need or want them is at best a difficult matter. For that reason, we are pleased that S. 1708 appears to provide strong linkages to comprehensive health programs for the delivery of family planning services. We agree with this approach for establishing accountability, but we would hope that either in the provisions of the bill, or in the committee report establishing legislative intent, that you will urge the Department of Health, Education, and Welfare to create additional linkages with educational programs, agencies and institutions, particularly the home economics programs that have a major concern for family planning services.

We urge the subcommittee to broaden the concept of this legislation to go beyond the medical, or clinical aspects of family planning. It should recognize family planning as a part of the decisionmaking

process related to the rights of parents and children. Conflicting values and attitudes often need to be clarified before a decision can be made. Recognition needs to be given to the fact that often no decision is made in a conscious manner; lives begin by default.

Our experience in the international family planning project helps to illustrate these points. For example, officials in Taiwan have described that country's family planning effort as an emergency measure designed to be a relatively short-term program with a long-term impact. It is recognized that the large sums of money allocated for this effort cannot be continued over an extended period of time. Therefore, conflicting values and attitudes are being identified and a variety of educational approaches are being developed to effect lasting change.

The situation in Taiwan is not unique. In our country, approximately 4 million women do not have the option to plan for family size and child spacing due to a lack of knowledge about contraceptives, a lack of decisionmaking ability, or a lack of clinical services. Therefore, it would appear that a structure needs to be built through educational programs, both formal and informal, including small groups and person to person contact, and designed to reach all age levels. This would help to create an awareness of the population situation and to equip persons to make knowledge-based decisions.

The data indicate that youth are a critical group to be reached. In 1972 Marion Howard reported for the consortium on early childbearing and childrearing that in the United States, 1 out of every 10 girls becomes a mother while still of school age (before reaching the age of 18). Close to 85 percent attempt to mother the child rather than placing their babies for adoption. School-age mothers, unmarried or married, are high risks educationally and medically.

Educationally, school-age mothers are high risk because pregnancy is the major known cause of school dropouts among females in the United States. Medically, they are high risk because of increased health complications during pregnancy and the high incidence of low-birth-weight, prematurely born babies. Moreover, these mothers often fall into a pattern of rapid repeated childbearing with increased negative health consequences for both mother and child. It should be pointed out that there is no evidence that knowledge of contraceptive techniques leads to increased sexual activity. Programs for youth would be designed to protect those who are sexually active and to provide a knowledge base for adulthood for others.

An already established educational effort is the expanded food and nutrition program, begun by the Cooperative Extension of the U.S. Department of Agriculture in 1968 with a mandate to serve "hard to reach" families. To do this, program aides were recruited from the group to be served. Research by Jean Brand to ascertain and describe the status and need for family planning information and communications as perceived by the program aides indicates that the families with whom the program aides work wish to have family planning information. An overwhelming 93.7 percent of the aides declared that these women and girls need information on family planning. They attribute nonuse of birth control to (1) fear that the methods are dangerous; (2) lack of knowledge of how to use them, and (3) objection of the male partner. Brand reports that 97 percent of the aides are giving advice, mostly of the referral type, directing women to health services. If trained, 87 percent of the respondents will teach family planning,

preferably working with women on a person-to-person basis. Aides and their clientele are not particularly high users of the mass media and do not wish to use media in teaching. The study indicates a need for in-service education about family planning and population concerns for paraprofessional as well as professional personnel.

We recognize the importance of research to develop contraceptive techniques that are more easily used and more effective. At the same time, we urge that some attention be given to research that would give us a better understanding of values and identification of other factors that affect family size and child spacing. Service programs and educational materials that are developed should give persons opportunities for becoming aware of their values and how they may operate in decisions made relating to population concerns and family planning.

We believe this bill will strengthen individual and family life because it can provide realistic options for family planning. It can provide for chosen children rather than unwanted children. There is a great deal of evidence that indicates the human and social costs of unwanted children.

The American Home Economics Association is confident that home economists can provide some of the competencies that will be required in the implementation of this program.

We urge early passage of S. 1708.

Thank you.

Senator CRANSTON. Thank you very, very much.

STATEMENT OF MS. DOROTHY LASDAY, MEMBER, NATIONAL BOARD, AND COORDINATOR OF STATE LEGISLATION OF NATIONAL COUNCIL OF JEWISH WOMEN

Ms. LASDAY. I am Dorothy Lasday, member of the national board and coordinator of State legislation of the National Council of Jewish Women, an organization founded in 1893 with a membership of over 100,000 located in communities throughout the United States.

Our organization has concerned itself with family planning since 1930 and at our 30th Biennial Convention held in Miami Beach, March 26-29, 1973, the following resolution was reaffirmed:

The National Council of Jewish Women believes that a healthy community, sound family life and individual welfare are interdependent and thrive when barriers of poverty and discrimination are removed. It believes, therefore, that our democratic society must give priority to programs which meet the economic, social, physical and psychological needs of all people, and that the public and private sectors must work together to help individuals function successfully and independently in a changing society.

It therefore resolves:

10. To support and promote programs for birth control including research, education and clinical services for all.

We wish to strongly, therefore, support the passage of S. 1708. President Nixon in 1969 made clear the necessity of meeting the family planning needs of all Americans. He particularly emphasized:

* * * that no American woman should be denied access to family planning assistance because of her economic condition * * * we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them. This we have the capacity to do.

The record shows that if the level of appropriations recommended by the DHEW 5-year plan had been followed, then the timetable for providing these services would have been met. However, because of the President's veto of the Labor-HEW appropriations bill and the resultant freeze on funding of the Family Planning Services and Population Research Act, we were 1 year behind that schedule. It is estimated that 2,612,000 persons received family planning services in fiscal year 1972. The goal of reaching the 6.6 million women who need family planning has not yet been reached, however, and most likely will not be reached if S. 1708 is not passed. The levels of funding provided in this legislation are the minimum necessary to reach that goal.

In providing this kind of health service it is important that every precaution be taken to make certain that it is sought and accepted voluntarily and offered in a manner and setting that is dignified and tied in to other related services.

For these reasons we applaud the provisions in S. 1708 that call for:

- (1) programs to be located where they will serve "persons from low-income families" and other persons at high risk of unwanted or health threatening pregnancy;
- (2) the provision of services to all individuals without qualification as to their personal or family level of income;
- (3) all programs funded through this legislation to be voluntary and not a "prerequisite to eligibility" for participation in any other program; and
- (4) "the arrangement for the provision either directly or through linkages with other health providers, of a comprehensive range of child and maternal health services to those persons or families to whom family planning services (will be provided under this title)."

We must recognize that many marginal income families are not in contact with their local departments of social services—they do not receive public assistance or any services. It is unrealistic to expect that they will go into the county social service office for family planning assistance. Therefore, it is important to provide such services through other public and nonprofit voluntary agencies. It is important that these funds be designated for family planning or many communities will have no family planning services.

It is clear that low income women have not had adequate access to family planning. Middle income women have received contraceptives from private physicians but no one has access to the perfect contraceptive. Oral contraceptives are the most popular method of contraception in this country, but they require daily application and medical monitoring as well as being expensive. Most important though are the uncomfortable and sometimes serious side effects associated with use. For these reasons, many women must discontinue its use, and numerous others suffer irritating and sometimes dangerous side effects.

Other means of contraception are less effective. Thus we must have more and better contraceptive research in order that women and their families may have the ability to plan for the size of their families.

It is difficult to understand why this legislation is opposed by some groups in view of the fact that it is a voluntary program. Any effort to deny individuals this service is an infringement upon their individual rights to plan for their families as they see fit. This is particu-

larly true of those who cannot afford services from private physicians.

We urge the committee to report this legislation favorably and to promote its passage without delay.

Senator CRANSTON. Thank you very, very much.

STATEMENT OF FRANCES M. FLIPPEN, WOMEN IN COMMUNITY SERVICE LIAISON, NATIONAL COUNCIL OF NEGRO WOMEN, INC.

Ms. FLIPPEN. Mr. Chairman, my name is Frances M. Flippen and I am representing the National Council of Negro Women, Inc.

This national organization is made up of 25 national organizations and 156 local sections with an outreach to 4 million women representing all religions, creeds, and national origins.

We cannot stress too emphatically the importance of health maintenance for the millions of poor people in this country—this grouping has become the “invisible” among us.

After years of neglect, the critical areas of family planning services and population research in the health maintenance area have been given high priority.

It became a significant part of the present administration's national goals—in that adequate family planning services were to be provided to all those who wanted them but could not afford them. Increased research was also noted as being a vital part of a national goal.

As of June 1972, an estimated 2.6 million individuals, three-quarters of them low income, were receiving family planning services in all public and private organized programs. I need not remind you that out of the low income figures are the black families and most importantly the black woman. The most vulnerable to the ravages of what I would deem to call socioeconomic pollution.

Family planning in its most positive sense is the provision of those services necessary to plan for life and living. Through education and professional help we can prevent the tragedies that are spawned by ignorance, fear, misinformation and neglect.

Research, statistics, surveys, analyses are bulging from the library shelves. The figures between the covers tell an awesome story about years of little or no health services. The untold sufferings of the least of these in our society is an irreparable part of the history of social neglect in this country.

The concern that the National Council of Negro Women has is that unless the Federal Government maintains and sustains its major support of and for family planning services and population research, the national goals as enumerated will not be achieved.

The States cannot sustain such a program, if Federal support is phased out and replaced with revenue sharing. The needs and demands in the States for funding of other programs will easily and quickly gobble up the revenue.

The on-the-spot experiences of black women in our local chapters in most of the States afford us documentary evidence of the struggles that families have and the piddling amounts of State dollars that are allocated to health services. There are no demonstrable examples that other State-administered health programs have financed any significant part of a family planning program.

Unless family planning and population research maintains its Federal direction and support, we are concerned that:

(1) It will not be possible to achieve the national goals set by the administration.

(2) A significant number of local family planning projects will fold or be curtailed, leaving hundreds and thousands of low-income women without access to effective family planning services.

(3) As a result there will be an alarming increase in the health hazards amongst the high risk population, notably the black family, and as well as the "rip-off" of strides made in the past years, however faltering, in providing health maintenance for this vulnerable population.

We, the National Council of Negro Women, strongly feel that the family planning programs will not be able to survive. The program as it is now constituted remains the "best of all possible worlds," in giving the women for whom we have priority interest and the most concern, adequate tools to function productively, without the psychological, economic, and emotional scars, for which the wounds of past inequities have just begun to heal.

A program of this magnitude must depend in major part on the Federal Government for its implementation. The National Council of Negro Women pledges its support through its local volunteer efforts to do its utmost to publicize the program. It cannot assume the responsibilities for which the Federal Government has the financial support and subsidiary backing.

We strongly urge that the Family Planning Services and Population Research Program, which now provides the bulk of Federal funds for the support of these programs, be extended at funding levels commensurate with the plans set forth that are comprehensive, organized, and structured.

Thank you.

Senator CRANSTON. Thank you very much.

STATEMENT OF MS. EDITH BARKSDALE-SLOAN, EXECUTIVE DIRECTOR, NATIONAL COMMITTEE ON HOUSEHOLD EMPLOYMENT

MS. BARKSDALE-SLOAN. I am executive director of the National Committee on Household Employment, and with me is Mrs. Josephine Hulett, national field officer for the committee. I am happy to have the opportunity to testify before the Special Subcommittee on Human Resources in support of S. 1708.

The National Committee on Household Employment is a private, nonprofit, organization concerned exclusively with private household employment and the more than 1.1 million workers in this occupation. As 97 percent of all persons employed in private household employment are women, we are naturally very concerned about the special problems which affect women, which, of course, would include family planning, population research, and maternal and child care. Since virtually all household workers (or domestic workers as they are often called) belong to the category known as the "working poor," they are especially affected by the lack of low-cost or free family planning counseling and products and the lack of adequate pre- and post-natal care and infant care. According to the 1970 census, the average

hourly wage for private household workers in 1969 was 90 cents or \$1,400 for a full, 50-52 week work year.

In only seven States and the District of Columbia was the median annual income for household workers, over \$2,000 per year for 50-52 work weeks per year. As you can see, this is certainly far below the poverty level income of \$7,200 for a family of four established by the U.S. Department of Labor. In addition, the median education for household workers is 9.1 years; and over half of them are members of minority groups, the greatest number being black women. Although the median age for household workers is 46 years, nearly half of the workers are in their childbearing years and many women in the other category would have young daughters or other female dependents who have reached puberty. In addition to being persons from low-income families, because of lack of sufficient education and poor health care, they would also be found among persons at high risk of unwanted or health-threatening pregnancies.

Now that I have established our legitimate interest as women from low-income families, I would like to explain our reasons for supporting the Family Planning Services and Population Research Amendments of 1973. I know that all of you have heard members of minority groups express their concern that Family Planning and Population Control is but the majority's euphemism for a diabolic scheme of genocide aimed at the Nation's minority groups. Owing to our sad history as members of America's minorities, this is always a legitimate fear—even though it may sound like paranoia to most members of America's majority or middle America. We do fear being eliminated and as many of us witnessed an example of it during our lifetimes in Hitler's Germany, we cannot truly believe that it absolutely cannot happen here. That is one reason why I was delighted to read section 1007 of the proposed legislation on "voluntary participation" by individuals in family planning. This section is a necessity, not only for the protection of minorities, but for the protection of our individual right of privacy. If this legislation becomes law, one important function of the Office of Family Planning and Population Science will be to insure that the program remains voluntary and that no State or its agencies or its individual agents attempts to make the acceptance of family planning counseling and therapy a prerequisite of any other service or assistance.

As a Black woman from a working class background, I am often surprised to hear the argument that black and other minority group women are not interested in family planning. From my own experiences and conversations with thousands of black, brown, red, and other minority group women, my conclusion is that that argument is utter nonsense. I have not met a woman in my lifetime who is not concerned about unwanted or high-risk pregnancies. We too want and deserve to have the opportunity to plan our families, to bear our offspring when we want and can afford them. We, too, want the best in prenatal and postnatal care for we value healthy bodies also. We, too, want the best health care for our infants and children, adequate food and living facilities and clothing and good educations. These are also our wishes and desires for ourselves and our children. These desires and needs are not limited to middle America. And so, we are in desperate need of good family planning counseling and reliable harmless contraceptives. We grieve when our babies are stillborn, too. We are in desperate need of good child and infant health care. We love and value our

babies, too, and want them to be healthy and intelligent and happy. Without good prenatal and postnatal and infant health care, they cannot be healthy or intelligent or happy.

One of my greatest joys is to see my 2-year-old son, strapping, healthy, and as bright as the Sun enjoying and learning from Sesame Street or Mister Rogers. All other mothers deserve to share my joy, but many need aid if they are to produce and rear, healthy, bright, and happy offspring. They must also plan their families as I am planning mine. I daresay that all of the blacks I have heard speak out against birth control have been black men or women who are beyond their childbearing years. As Ms. Hulett will tell you, the male participation in the conception, gestations and birth process takes but a few moments. It is the woman who must carry the child for 9 months and experience the agonies of childbirth. It is the woman who must nurture and care for her infant and young child. While the father might (or might not) be concerned and interested, it is by nature a primary concern for the mother. As far as I am concerned, black men could scream genocide until they were hoarse and I would ignore them as they are not the ones who become pregnant. If he could, I daresay he would think twice about it.

While I am on the subject of male participation in the birth process, I must also express my concern for the rather well-accepted attitude that the female is responsible for birth control. As I am sure you have heard other women say, we cannot become pregnant by ourselves. We do need the participation of a man. And why is he not also responsible for family planning or birth control? Why hasn't some bright male scientist invented a pill with side effects and unknown long-range effects for the men to ingest? I, for one, am tired of being the guinea pig in my family. I consider family planning a dual responsibility, and I would like to see reliable contraceptives developed for men. I belong to that growing minority of women (approximately one-third according to my doctor) who cannot use the diaphragm or IUD. I have already had one unplanned Delfin baby, and I should like to have my next child when my husband and I are ready for her. I do want a daughter, but not now. That means that either I take the pill or abstain; and abstention is against my marriage vows and contract and against human nature. That means that I must suffer side effects and the risks which go with the pill. I think it's my husband's turn now, and I hope that some of the population research will be aimed at developing a safe, reliable contraceptive for men.

We, as women, are also vitally concerned with infertility. Most black women place a high value on the ability to have children and are crushed when they learn for some reason that they are unable to do so. We, too, need and desire counseling on infertility.

Lastly, we are very concerned with the risk of unwanted pregnancies for our teenage daughters and the even greater risk of giving birth before their bodies are sufficiently mature. Whether we like it or not, a new standard of morals has developed over the past 20 years, and the emphasis placed on premarital chastity has declined—if not practically disappeared. Teenagers are sexually active now, and they—like adults—need protection against unwanted pregnancies. They are also desperately in need of counseling—with or without their parent's consent. The lack of a parent's consent will not prevent the girl from becoming pregnant. We must be realistic about the changing times and

establish family counseling centers which will be open to all, both minors and adults. We need also to find contraceptives which will be just as effective for adolescents as they will be for adults. Also, we need counseling for teenage boys as well as girls for young boys should be taught to be responsible for their actions as well as teenage girls.

Mr. Chairman, Sunday is Mother's Day. On behalf of all the women in America who are mothers because they lacked reliable contraceptives, I ask you to honor us by resolving to work for the passage of the Family Planning Services and Population Research Amendments of 1973. That would indeed make Mother's Day a happy day. Thank you.

Senator CRANSTON. Thank you very, very much for that eloquent statement. I would like to ask you one question. The administration has stated that it proposes to base any expansion of family planning programs on services provided by private physicians who would be reimbursed through medicaid or through title IV of the Social Security Act. A careful reading of the administration's testimony seems to indicate that after fiscal year 1974, they propose to phase out project grant support for family planning. How do you feel as a representative of a minority group viewpoint that utilizing medicaid and social security authorities for the expansion of family planning service programs would work?

What would be the reaction to that?

Ms. BARKSDALE-SLOAN. I feel this would be an injustice and would discriminate. According to this booklet promulgated by the Department of Health, Education, and Welfare on medicaid and medicare, published in July 1972, there are 25 medicaid programs, which cover people who are eligible for public assistance only.

Now this means that in those 25 States, people who are among the working poor would not be eligible to receive this counseling and this aid. And I note that at least 10 of these States are in the South, where 55 percent of household workers reside, and at least three in other States where there are heavy concentrations of household workers. For this reason I would oppose that because that means that would eliminate in those 25 States the aid to working poor who need it just as desperately as recipients of welfare.

Senator CRANSTON. Would not that approach also feed the fuel of the fires of those who feel there is a genocide aspect to it; while it eliminates working poor, it does not eliminate the nonworking poor?

Ms. BARKSDALE-SLOAN. This would be fuel for that fire. This is an euphemism for genocide. I think it would be detrimental to the whole process of trying to evolve a good national family planning program for middle-income people, as well.

Senator CRANSTON. As far as enjoying Mother's Day, you know my attitude on the bill.

Ms. BARKSDALE-SLOAN. Yes.

Senator CRANSTON. Do others of you wish to comment on the questions that I posed at that point?

Ms. LASDAY. We feel family planning must be a program that is available within the community where the family is living, one that does not have the stigma of welfare or public assistance. We have very few services that are available in this country to marginal income families, working poor, moderate income families, who have been priced out of the private health care area.

**STATEMENT OF MS. JOSEPHINE HULETT, FIELD OFFICER,
NATIONAL COMMITTEE ON HOUSEHOLD EMPLOYMENT**

Ms. HULETT. Thank you, Mr. Chairman.

I am Josephine Hulett, field officer for the National Committee on Household Employment and I am delighted to have an opportunity to testify before the Special Subcommittee on Human Resources in support of S. 1708.

Since household workers are among the lowest paid workers in this country today, it is very important that we tell you the things that cause me to say we must be able to plan our own families. It affects the lives of our children, as many of them have reached their child-bearing years.

The mother is always the mother and the father is the father only once. She usually gets the child in case the marriage is dissolved and in many cases the children come with no child support. And if there is child support ordered by the courts, it is seldom enforced. Believe me, I know what it is like to wait for support money and it does not come. Also, in most cases no one will rent to you because of the problems which they feel may be involved in collecting the rent.

As a mother you take a job for security as a household worker which in most cases is for less than the Federal or State minimum wage. According to society, household work was the only thing I could do. I worked late hours and there was no child care center at which I could leave my child. And if my child would have gotten into trouble, then I would have been charged with child neglect, not the father, or had been called an unfit mother. And if I had gone on welfare then that meant I was lazy. My weekly pay was \$22.50 when I was trying to support my son.

Things are no different now than in 1957. The only thing that has changed is the fact that we will no longer let ourselves be told we are only women. We see the common bond and we are out to change that which has kept us afraid to speak out.

I have just received a letter from a 14-year-old with two children whose mother is a household worker whom I had befriended in my travel to Huntsville, Ala., where contraceptives are not readily available not only for teenagers but for anyone. She asked me what I thought she should do. As I mentioned, she is the mother of two children at age 14 and she stated she was not quite aware of contraceptives and did not know what to do. Her mother is unable to support another family and she is too young to get a job according to the law. This situation alone proves that we must change this system so that contraceptives are readily available to individual needs.

Many household workers have been evicted or have had to sign papers as I did upon entering the Metropolitan Housing in the State of Ohio saying if I became pregnant, that I would be evicted. Many women cannot use the contraceptives due to health problems. But it is always up to the women. We must realize that this is a problem of all people and it should not be geared to women only. Also, 9 times out of 10, the contraceptives are not safe and it causes many major medical problems for women.

I cannot stress sufficiently the importance of this legislation, not only as a former household worker, but as a mother. I hope that you will give it your utmost consideration.

Thank you.

Senator CRANSTON. Thank you very, very much.

I thank each of you for your presence and interest and your testimony.

Senator CRANSTON. We will now proceed with the second panel.

Would you proceed in your own way.

STATEMENT OF AUDREY COLOM, VICE-CHAIR OF THE NATIONAL WOMEN'S POLITICAL CAUCUS

Ms. COLOM. I am Audrey Colom, vice-chair of the National Women's Political Caucus and coordinator of the District of Columbia Women's Political Caucus. The National Women's Political Caucus was formed in July 1971 to organize and assert the vast political power represented by women—54 percent of the voting population. The Caucus is a multipartisan coalition of women from various backgrounds, economic levels, and political affiliations who have united in the interest of all women. We now have approximately 50,000 members from 500 State and local caucuses around the country. We are reaching out to women across the country because we believe that women must take action to unite against sexism, racism, institutional violence and poverty.

At the Caucus's first annual convention in Houston, Tex., during February 9 through 11, 1973—the first women's political convention in over 100 years—we adopted by unanimous consent the following resolutions regarding health care for women:

Resolved, that we support an agenda for the 93rd Congress that would . . . include in any health security program, coverage of all women's health services (including prenatal, delivery and postpartum maternity care; voluntary contraceptive services, sterilization, abortion, infertility and other fertility-related services) without coinsurance or deductibles and without regard to age, marital or economic status. The National Women's Political Caucus rejects any effort to coerce women to have or not have children.

Until the above program becomes reality, continue and expand the Family Planning Services & Population Research Act (title X of the Public Health Service Act) to provide family planning services and to expand development of new and surveillance of existing contraceptives.

The women of the caucus adopted these resolutions because we believe the programs under title X of the Public Health Service Act are of primary importance to the health of women and because there is an urgent need for swift review and passage of legislation to continue the Federal commitment made in 1970 to provide subsidized family planning health care to all women who want and need these services but who cannot afford the cost of private physicians for these services. The 2.6 million women who are now receiving comprehensive services under these programs should not be turned away from services because this law is allowed to expire. Furthermore, this law must be continued and funds for it must be increased so that all the 6.6 million women who want family planning health services may be reached. Moreover, programs under this act must be continued so that the nearly 45 million American women of childbearing age—and as many men—will have safer, more effective, and more acceptable methods of contraception. New technology, enabling each individual to control his or her own fertility, is desperately needed, and until it is developed no individual is truly free.

The national research effort in developing safer, more acceptable contraceptive methods for men and women is dependent upon funds

authorized under this law. If this law is allowed to expire, individuals will be forced to continue to rely on methods whose long-range effects are unknown, methods with serious disadvantages, and methods with potentially hazardous side effects. We believe that the state of fertility control technology is still in the dark ages especially as compared to scientific advances in other fields. Our two most modern contraceptive methods, the IUD and the pill, are physically or medically unacceptable to a large segment of women of childbearing age.

For example, many women cannot use oral contraceptives because of related medical problems such as high blood pressure, heart and kidney disease, and sickle cell anemia. As a black woman, I am particularly concerned about this because, while I am opposed to compulsory screening programs of any kind, sickle cell anemia is found almost exclusively among blacks and, furthermore, the incidence of hypertension is higher among black women than among white women. The numerous contraindications for pill use make this an unacceptable method for general use. It has been 16 years since the oral contraceptive was introduced for general use. Its long-range effects are yet unknown. Concerning another method, the IUD, which is somewhat less effective than the pill, many women experience unpleasant or painful side effects and its use is often discontinued after a short period of time. Use of this method is also contraindicated for many women with a history of menstrual problems. Moreover, the IUD is hardly a breakthrough in modern scientific technology. It is based upon the ancient practice of inserting a stone in the uteri of camels, which was found to prevent conception. How this contraception occurs, either by stones or IUD's is still unknown.

Women use these and other methods because there are few alternatives. But we are not satisfied with them. A recent study by the center for family planning program development has determined that in the United States today there are between 10 and 13 million women at any given time who are practicing contraceptive methods which are inadequate to meet their family planning needs. Thus, it is not surprising that unwanted or accidental pregnancies are experienced by more than half of all American couples. Millions of women have been forced to bear unplanned or unwanted children or have had to experience the physical and psychological trauma of abortion.

The Supreme Court decision on abortion is a great milestone regarding a woman's Constitutional right to privacy. We are acutely aware of how important the decision to have a child is, and we believe that women have the right to make decisions in matters affecting their own health and well-being. It is obvious that abortion is not to be taken lightly nor is it a healthy, optimum method of family planning. Despite its use, the need for abortion in our society remains an admission of failure on the part of our institutions and society as a whole to respond to the need for fully accessible, safe and effective birth planning methods. Our most modern methods do not provide women with complete freedom from unwanted fertility, and therefore women must continue to bear the burden of this inadequate technology. In light of this, the caucus at its Houston convention went on record in support of legislation to give public and nonprofit private agencies funds to establish and operate pro-

grams that would finance the costs of abortion, pregnancy counseling, adoption services and other referral services regarding options related to pregnancy. We will work for the adoption and passage of such legislation at the State and Federal level.

We strongly believe that all women who want them should be provided with family planning information and services so that they may make intelligent and well-informed decisions concerning childbearing and have safe and effective means to carry out such decisions. Title X has been successful in removing the economic and social obstacles that prevent poor women from obtaining these services. Projects funded under this Act have served to give to low-income women those rights and benefits generally available to middle- and upper-income women—periodic gynecological examinations, Pap tests, breast cancer screening, and other diagnostic care which is essential to good health. If this categorical program is not continued, millions of low-income women will have nowhere to turn for this basic health care. Advances in scientific knowledge about human reproduction may never be realized, and our contraceptive methods will never be improved. Millions of low-income women will be consigned to poor health, welfare, and the oppression that has been uniquely reserved for them—indifference.

We therefore strongly urge enactment of S. 1708.

In closing I would like to add, fully understanding the need for the Congress this year to be fiscally responsible, we do not want our Congresspersons and Senators to forget the human needs of millions of women, children and men.

Thank you.

SENATOR CRANSTON. Thank you very, very much.

STATEMENT OF SARA M. MAZIE, VICE PRESIDENT, NATIONAL CAPITOL CHAPTER, WOMEN'S EQUITY ACTION LEAGUE

MS. MAZIE. I am Sara Mills Mazie. I represent the Women's Equity Action League, which is a nationwide women's rights organization devoted to improving the status of women through education, legislation, and litigation. Our membership includes women from all walks of life—working women, housewives, professional women, students and senior citizens.

In the past 3 years our organization has filed charges against 250 colleges and universities to obtain equity in salaries and employment practices. We are working to see that the equal pay law is enforced, and to insure that equal employment laws in fact eliminate sex discrimination.

Mr. Chairman, we know and wish to inform the Congress that there is nothing that has the potential for more seriously affecting the economic status of women than the ability to control fertility. Until we can do this, our search for equality will be severely hampered. The first step in controlling our lives must be the ability to control whether and when we have children.

For this reason, the Women's Equity Action League strongly supports the passage of S. 1708, the Family Planning Services and Population Research Act of 1973. It is the purpose of this legislation to carry through on the program begun in 1970 of making these services

available to all women who want but cannot afford them and to increase research into improved methods of contraception for all men and women.

Most middle-income women have had, at least for the past several years, access to contraceptive information and services through private physicians. Low-income women, however, who do not have private physicians, had been denied the ability effectively to plan their families until initiation of the Federally subsidized family planning program. As a result, unplanned and unwanted pregnancies occurred much more frequently among low-income women.

The importance of family planning services to the economic well-being of these women has been demonstrated in a study on the costs and benefits of the program. The study states:

***nearly half of the patients of organized family planning programs are likely to be employed. Since almost all patients have low or marginal incomes, it is assumed that they work in lower paying jobs—clerical, sales, private household service or other service. Based on these assumptions, it appears that each birth represents a . . . cost in the year of pregnancy . . . of about \$1,044 in lost earnings alone.

It is clear that the loss of income due to unwanted or unplanned pregnancy may be disastrous for a low-income woman, especially one supporting a family. Unplanned and unwanted pregnancies are not limited to low-income women, however. Because the state of contraceptive technology is so grossly inadequate, all women are threatened by the inability to avoid unwanted pregnancies. All existing methods of contraception have serious flaws that make them unsafe, unacceptable or inefficient for some individuals.

Part of the reason that contraceptive technology is so limited is that, until recently, the Federal Government would not use Federal funds to support research in this field. For example, in the 1950's, scientists working on oral contraceptives were unable to secure the small sum of \$300,000 from the Federal Government for initial development of that drug. This primitive and limited attitude has been greatly but not completely eradicated. It is clear that, whereas such research is now acceptable, it is clearly not a priority. Federal funding in this field has been limited to \$39 million per year for the last 3 years.

Women's Equity Action League believes this figure is so low as to be insulting. The amounts stipulated in S. 1708 are considerably better but still lower than what many experts believe are necessary to support a reasonably adequate program that will produce new breakthroughs within the next few years. We would urge the Committee to increase the amounts designated for research to a point where they will reach \$150 million by Fiscal Year 1975. There are few issues before the Congress at any time that have the potential to affect over 84 million Americans. This is the number of men and women in our century in their reproductive years. Virtually all are seriously affected by the course of contraceptive research. We urge the Congress to increase funds for this field and to act quickly and favorably on S. 1708.

Thank you.

Senator CRANSTON. Thank you very much.

**STATEMENT OF VIOLET MALINSKI, CHAIRPERSON, MARYLAND
TASK FORCE FOR REPRODUCTION AND POPULATION OF THE
NATIONAL CAPITAL AREA OF NOW, AND REPRESENTATIVE OF
THE NATIONAL ORGANIZATION FOR WOMEN**

Ms. MALINSKI. My name is Violet Malinski of Maryland, and I am here today as the task force chairperson for reproduction and population of the National Capital Area Chapter of NOW, and as a representative of the National Organization for Women, a feminist organization of nearly 40,000 volunteer women. We have a very strong record of political activism in the area of civil rights, which is what I wish to discuss with you today; namely, the rights of women with regard to their reproductive lives vis-a-vis the oppression of society and the laws.

There are millions of poor women in the United States. Even though many women are employed, their average salaries qualify them as the "working poor." Poverty is indeed a women's issue. The Family Planning Services and Population Research Act of 1973 was passed to guarantee poor women the opportunity to obtain birth control services. Prior to the establishment of the large programs under this act, many women in the poor or working poor category had not been able to get birth control services because they could not afford to see a private physician. They were therefore punished by society for being poor by having to choose between complete abstinence or pregnancy, a choice that would not be attractive to most women (or men, if they had to face it). Many women then, of limited income, were forced into pregnancy, followed by either an illegal abortion and the death this sometimes meant, or by the bearing of a child.

Since the passage of this act and the establishment of the family planning services programs under it, 2.6 million women in need of subsidized family planning services have received them. However, there are still 4 million of our sisters who cannot afford birth control services and have not been able to obtain them through these subsidized family planning services programs; they need our help. Therefore, I agree with the legislation's extension of the family planning services programs for 3 more years and with the increased authorizations to fund the expansion of services during that time. This is consistent with the national policies of NOW.

I would like to suggest, however, to the committee that you increase the authorization for services under this bill so that men are also fully covered. I believe that all men who need birth control but cannot afford it should be able to obtain services through this program. All clinics should stock condoms, and instructions on the proper use of them should be included in the standard services. I also think vasectomies should be available through all the programs for men who want them.

As a former public health nurse I know that many young couples depend on condoms as their only method of contraception and that all too few know anything about the proper use of them, especially those in their teens. I believe that these programs, therefore, could offer

young men their chance to learn about responsible behavior with regard to controlling their own fertility. This is another step that must be taken if couples are to be truly guaranteed the right to plan their families and will enable both men and women to share equally in responsibility for their own reproductive lives.

I would like to commend this committee for making services available to women regardless of age or marital status. I believe that very young women, especially those in their teens, are often forced into dependency by the birth of a child which they did not plan or want. I have seen 14-year-olds become pregnant because they did not have the money to pay for a private physician to get birth control and, even if they did, the physician would not give them any birth control without permission from their parents. This stipulation that a parent must give permission for a sexually active woman to obtain birth control services constitutes an invasion of a young woman's privacy and sexual life; it is also another way that society punishes a young woman for being a woman. Young men can go to the pharmacy and purchase a perfectly reliable method of birth control over the counter without parental consent. Young women must go to a physician or clinic, since the only reliable methods for women require prescriptions, including the diaphragm, and there they are told they must have parental consent. Yet it is the young woman who faces the danger of unwanted pregnancy. This is no equitable situation.

I also agree with the committee's stipulation that there should be no income or means tests for these programs. I know from experience that a person seeking clinic services does so because she or he cannot afford a private physician. I do not think that anyone who could afford private services would willingly sit for hours in the crowded waiting room of a public clinic.

I am definitely in favor of the related health services which are provided through the family planning service programs, and I commend the committee for its requirement that patients be referred for maternal and child health and infertility services should they so require them. The women who need birth control services also need to have regular gynecological checkups, pap smears, lab tests—the works. Since the birth control service may be the only medical service they receive, I am pleased that you make it as comprehensive as possible. It is particularly important that women who are using the oral contraceptive or have an IUD be checked regularly so that their general health may be protected.

With regard to the pill and the IUD, I would like to state that I do not believe that either one is particularly desirable for long-term usage. The complications and side effects associated with them frighten many women, including me. For this reason I particularly support your efforts to increase the funds and priority for contraceptive development research. This is also consistent with the national policies of NOW which I would like to read at this time and insert in the record:

The basic human right to limit one's own reproduction includes the right to all forms of birth control (contraception, including sterilization, and abortion), recognizing the dual responsibility of both sexes. We therefore oppose all legislation and practices that restrict access to any of these means of birth control and advocate positive measure requiring:

That all public hospitals offer contraception, sterilization, and abortion to anyone requesting these services;

That these services be made accessible to as many people as possible by the establishment of a network of local public clinics;

That the availability of these services be widely and continuously publicized; That public funds be allocated for research into new methods of contraception, sterilization, and abortion which would increase their safety and availability.

I also want to suggest that your committee report should stress that a male method should be developed which is as easy to use as the oral contraceptive and the IUD. It is also my hope that a method of birth control will be developed which is safe, easy to use, inexpensive and sold over-the-counter for women so that we could avoid the whole parental consent controversy.

Finally, I would like to comment on section 1008 of your bill. I do not believe that abortion is a method of family planning; I do not know of any woman's organization which sees abortion as a substitute for contraception. However, I would like a clarification of 1008. Would it prevent abortions which are necessary to preserve the life or the health of women and in the instance of contraceptive failures? If section 1008 would proscribe the use of funds for these therapeutic abortions, then I must oppose it and demand that it be stricken from the bill. It is the national policy of NOW that we oppose all legislation which restricts access to abortion.

I realize that the costs for therapeutic abortions would be more than the costs of birth control, so I would suggest that you attach additional funds for these purposes.

I would also like to say that if this section excludes the use of funds for pregnancy testing and counseling since these are vital to us, I would oppose this section. If a woman comes to a birth control clinic for services, and is found to be pregnant, I do not think she should be thrown out into the streets without being advised of the alternatives that are possible for her, including abortion or residential homes for unwed mothers. If section 1008 would proscribe the use of funds for pregnancy testing and counseling of this nature, then I would also have to oppose it on NOW national policy grounds. I would ask instead that you specifically add pregnancy testing and counseling to the list of services available under this act.

Finally, I would urge that section 1008 be stricken if it affects the research program in any way. It is my hope that research on menstrual extraction will soon prove it to be safe or that some other method will soon be discovered that will make what we know today as abortion an obsolete word. I do not know of any group but the right-to-life group backed by the National Catholic Conference and the bishops which wants to hamstring researchers by prohibiting them from doing research which may lead to the discovery of something which may be described as abortifacient. I believe this would greatly hamper scientists in their efforts to find new contraceptive methods of any kind.

That completes my testimony on S. 1708, Mr. Chairman. However, I would like to direct some comments to you. I came here today in good faith to testify on the family planning bill. I did not intend nor did I suspect that anyone would be allowed to make this a forum concerning abortion, the proposed constitutional amendments on abortion or the proposed hospital prohibitions on abortion and sterilization. I do not know much about legislation, but I do know that this is not a judiciary committee and that you do not have jurisdiction over constitutional amendments. I have been greatly disturbed by the fact that you have allowed a hearing on family planning services and contra-

ceptive research to be taken over by anti-abortion groups, primarily the right-to-life groups. You have allowed them to co-opt this hearing, to shift the focus from the really important services and research and to harangue us for hours. You should have ruled them out of order and sent them home. I think it is obvious that they are trying to use their stand on abortion to sink this entire bill. It is obvious they do not care about what happens either to the women who are already receiving these services or to those yet to be served.

It is obvious they do not care about the pain and suffering that will be caused if clinics are closed and women turned away from birth control services. In fact, the right-to-life groups have distinguished themselves in their lack of concern about life; I mean the right to a decent life by those who are already living. I looked at them and I did not see anyone who had worked for peace in Vietnam. I did not see anyone concerned with the innocent lives of women and children that were destroyed in that war. Where were they when we were trying to stop the war? The Catholic bishops refused to pass a stop-the-war resolution at any time. Apparently the right-to-life groups reflect this.

And now, where are the right-to-lifers on the poverty issue? I have not seen any right-to-life literature urging the preservation of programs started during the last decade for the improvement of education, health, and housing for the poor. Again I am not aware of any resolution passed by the bishops calling on President Nixon to end his war on the poor women, men, and children of this country.

I know where the bishops stand on equal rights for women. We have met their opposition in State after State. Here, too, I have not seen any right-to-life literature urging support of the equal rights amendment so I must assume again they reflect the stand of the bishops.

The National Organization for Women is a civil rights organization; we strive to develop and to free individuals from those factors in society which suppress them. I could sit here and agree that abortion should be prohibited, after all, economically speaking, we need an oppressed class in this country. Because ethnic and racial minority groups refuse to serve this function any longer, the next logical group to oppress is women. How can society better shackle women and young girls than to strip them of their newly gained right not to carry a fetus implanted in their wombs against their wishes?

Instead we support the enlargement of the freedoms of the individual. We have taken strong stands against the war. One of our top priorities this year is the preservation of existing programs and development of new ones to combat poverty. We are working extremely hard for equal rights for women of all ages, races, religions, and creeds.

The right-to-life groups are for enslavement. Compulsory pregnancy and child-bearing is 9 months and 18 years of slavery. They are not a civil rights group. They work to limit the rights of women and of the young; traditionally, the most suppressed members of our society, even though a majority. They strive to mesh church and state, theology and law. They seek prohibitions on research, prohibitions on hospitals, even prohibitions in the constitution.

We realize that the Senate is an all-male body. We realize that none of you can ever know the terror of unwanted pregnancy and illegal abortion. We can only rely on your good will and on that of the

other Senators to protect our rights, to keep abortion a matter of personal conscience between a woman, her physician and her counselor. We ask that you help us keep matters of individual choice out of the laws. We ask that you help preserve our freedoms from those who wish only our bondage. We intend to fight them all the way, but the ultimate decisions will be in your hands. We need your help to maintain freedom and dignity for women and their families in this country.

Thank you.

Senator CRANSTON. Thank you very much.

I would like to say that I do not think any individuals or groups have taken over this hearing. This is a public forum, open forum, and all people, and all groups who feel that they have views that they want to present on this legislation or other legislation, when other legislation is being considered are welcome to present their views.

We do not know what those views are beforehand often. We have no right to censor these views, and we simply take into account what is said, where it is relevant to legislation. Where it is irrelevant, perhaps it is the responsibility of other committees and should be presented to the appropriate committee. But we cannot censor obviously.

We are delighted to have different viewpoints that people wish to express on pending legislation.

STATEMENT OF MS. CAROL BURRIS, PRESIDENT, WOMEN'S LOBBY, INC.

Ms. BURRIS. I am Carol Burris, president of Women's Lobby, Inc. The Lobby is a national organization with affiliates in 40 States and we work solely on women's legislation. We appreciate the opportunity to give you our views today and on an issue that concerns all women.

Because women bear children, and are socialized to rear them, often without any supportive services like child care, women cannot pretend to any freedom until they can control their reproductive lives. This country is terrifying in its socialization of women into a rigid role, but the most terrifying aspect of this role is the pronatal attitude women are taught. We are asked when we will have children, not if. Women without children can have no joyous experiences in this mythology.

Nowhere is this attitude more prevalent than in family planning. All contraceptives are designed to be used until one wants to be pregnant—completely ignoring the fact that the majority of women's lives are spent fertile and not wishing conception. This points up the nature of the administration's proposal to make this essentially a welfare service: surely women other than the poor can have all the children they might have. Only when the question of public funds are involved do we believe in setting limits. All women need these health services and all women are entitled to use services provided with their tax moneys.

Here we are discussing providing the services that are already available. Let us discuss the research that needs to be done. A close friend of mine is a cardiologist. She often points out that she is paid very well in an expanding field to do research on disease that primarily affects well-paid white men. I think the signs are clear to all of us that if the U.S. Senate Members could be pregnant, this bill would have little opposition.

Contraceptive research is at an infantile stage. Birth control pills, the peak of our research so far have so many contraindications that they strike me as analogous to the bleeding techniques of the Middle Ages as medicine. What other medicine that is taken daily has, as a possible side effect, death? When all the reports of a male contraceptive pill report that it was dropped because men could not drink while taking it are compared to the reports of clotting, headaches, and stroke, the sexist implications are clear.

There is no current method that does not have its failures so more research is badly needed. In self-help clinics across the country, women in the women's movement are examining their own cervixes for infection. They are also using a suction method of menstrual extraction for contraception. There is certainly debate about whether this method is safe or not. But it points up a hole in medical knowledge and research by a sexist medical profession who remark on the need for "motivated" women. In my opinion, if more research is not funded, we will see more of this self-experimentation, by women, on themselves and other women, due to a failure of medical institutions and congressional institutions to address themselves to this problem.

Since these hearings are about family planning and not about abortion, it becomes even more important to talk about the methods that can be used to prevent conception. A free and frank discussion of new contraceptives gives alternatives and more protection to those who oppose abortion. Renewing this bill and providing public health services in this area to women should also help to demystify virginity. This is particularly important for the sexually active young women who think that all current contraceptives mean a conscious decision. A decision this society prevents women from making rationally when it socializes them to believe that only men want sex and make sexual overtures. Combined with the mythology that every woman wants babies, this provides a powerful stimulus to pretend that no precautions are needed.

In conclusion, I would urge the committee to provide for the continued funding for title X of the Public Health Service Act. Anything less would be unfair to the majority of the population—a majority that has no representation on this subcommittee or in the whole of the U.S. Senate.

In conclusion, I would like to say that I think this panel and the preceding one were all women and that they are indeed a concerned group, and it was interesting that the right to lifers had a panel who had so many men who felt they could tell me what I should do; I would not deign to tell them what they ought to do.

Senator CRANSTON. Thank you very much.

STATEMENT OF WINONA BANISTER, VICE PRESIDENT, YOUNG WOMEN'S CHRISTIAN ASSOCIATION

Mrs. BANISTER. My name is Winona Banister—I am serving as vice president-at-large of the Young Women's Christian Association an organization representing some 2½ million members and participants, including 800,000 women in the child bearing years.

As a women's movement, concerned with the multiple dimensions of women's lives, we have had since the 1930's, a strong emphasis on the need for family planning services to be available on a voluntary

basis to all women, the poor and affluent alike. We have viewed the right of citizens to secure the services, which are fundamental to human survival and quality of life, as essential to the attainment of a just and open society for all people. Along with opportunities for adequate housing—quality education—suitable employment—and a life style conducive to physical, emotional and spiritual health, there must be open access to information and services related to family planning and responsible parenthood. We believe human values and human rights must be kept in the forefront of all policy decisions related to the voluntary limitation of population.

As a pluralistic women's organization, the YWCA includes a diverse racial, religious and socio-economic constituency. Our concern in educating family life has been to reflect the differing creeds, mores and life styles represented among us. We have stressed the right of each woman to freely make decisions about child bearing and the ethical and moral dimensions of this decision.

The concern of the YWCA has been increasingly centered on the needs of teenagers for sex education and family planning information. "The Report of the Commission on Population Growth and the American Future" alludes to the recent study of unmarried teenagers although 14 percent of the 15 year olds and up to 44 percent of the 19 year olds reported having sexual relations, only 20 percent used contraception regularly. In 1970 approximately 180,000 babies were born out-of-wedlock to teenage mothers.

The YWCA's National Resource Center on Women has been conducting a teen counseling project, in cooperation with the Bank Street College of Education, documenting the needs of teen women—2,000 teens representing a spectrum of geographical, age, racial and social strata responded through questionnaires and workshop sessions. The greatest need for help was in sex education, including information on contraceptives. The study, which is to be published this summer, highlights these facts: "sex education is not available in my school." "sex education classes provide incomplete information." "birth control information cannot be given." "parents tend to withhold information." "parents are judgmental rather than informative." The study points anew the need for well informed, sensitive and compassionate help for teens on the part of the parents, teachers, religious leaders, and social agencies. The YWCA believes that teens not only need sex education but information on birth control as a part of their training for responsible parenthood. The YWCA will be stepping up its efforts to provide counsel and referral to teens and parents, but adequate family planning services with comprehensive medical/health components are lacking in far too many communities. We with other organizations and agencies who are concerned with the physical, social and spiritual health needs of the young people in today's world could be much more effective if the kind of comprehensive services envisioned in this legislation were available.

While we have been greatly encouraged by their recent growth of family planning services, spurred on by Federal funds, and at the potential for further growth in response to urgent community needs, we have been most discouraged by the record to-date of the limited use of available funds by State health and welfare agencies for family planning services. The poor and sporadic record of medicaid and title IV is not reassuring either. The restriction of family planning

funds in title IV and the income limitations in medicaid both seem to eliminate a large number of working poor and lower income women who would otherwise have access to services. Most discouraging is the administration's proposal to give block grants to States for health services. This would appear to further diminish the chance for adequate assistance to the family planning and information services while the research and training programs are completely omitted. Also in the new HEW regulations, the implication seems clear that family planning is to be used principally as a service for welfare mothers—a tool to reduce family size and speed these women into employment.

At our most recent National Convention in March of this year, the delegates through our National Program for Action reaffirmed our intention to "ensure the availability of adequate services in sex education, family planning, and programs of education on population that are non-sexist and non-racist." The YWCA believes the extension of Federal appropriations for family planning services and population research is urgent and we strongly support the basic provisions of this bill. It assures a more comprehensive approach for making quality service readily available to all women in both rural and urban settings. We particularly support the need for assistance to expand and coordinate the research program for we are on the threshold of new learnings in the fields of human reproduction and population dynamics. Assistance for manpower training programs to assure the delivery of quality services is imperative and the need for the development of educational materials and information services has been constantly documented.

We appreciate this opportunity to report to you our concerns and our support of the basic provisions of this bill. We admire your stamina in making this hearing open to all of us and your patience in listening to all groups, whether you agree with their position or not. Thank you.

Senator CRANSTON. Thank you very much. I appreciate those kind words. I am grateful for your testimony. I want to thank each of you and the other panels again for your testimony. This panel has about five minutes left, so is there anyone else here who would like to say something? Or do you have anything to add?

Mrs. BANISTER. I would simply add in the course of the conversation in relation to abortion, the YWCA has worked for repeal of abortion laws, and was very pleased with the Supreme Court decision. We believe abortion is a medical procedure and not a method of family planning, and this is the reason why it does not appear in our report as part of our testimony.

Senator CRANSTON. Thank you very much. If there is nothing more for the record at this point, this hearing stands adjourned. I thank each and all of you for your patience and interest.

[Whereupon, at 5:42 o'clock p.m. the hearing was adjourned.]

FAMILY PLANNING SERVICES AND POPULATION RESEARCH AMENDMENTS OF 1973

WEDNESDAY, MAY 23, 1973

U.S. SENATE,
SPECIAL SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m. in room 4232, Dirksen Office Building, Senator Alan Cranston, chairman of the special subcommittee, presiding.

Present: Senator Cranston.

Committee staff members present: Jonathan R. Steinberg, counsel to the subcommittee; Louise Ringwalt, research analyst; and Jay Cutler, minority counsel.

Senator CRANSTON. The hearing will please come to order.

I apologize for the delay in getting started.

This morning the Special Subcommittee on Human Resources will conclude hearings on S. 1708, the proposed family planning services and population research amendments of 1973, and Federal family planning programs, which began earlier this month. Hearings were held on May 8, 9, and 10.

When the administration appeared on May 8, it presented to us its prepared testimony barely 1 hour before the start of the hearing. Thus, we were unable to ask the kind of detailed questions we felt necessary and have arranged this hearing this morning for the specific purpose of pursuing those matters covered or not covered in the administration's testimony in chief presented on May 8.

Very substantial testimony was presented in the earlier hearings that the administration's proposal to eliminate project grants under title X of the Public Health Service Act would inevitably result in a substantial decrease in family planning services supported by the Federal Government. I intend to pursue this at length with the administration witnesses this morning.

I also want to reiterate concerns I expressed in my opening statement on May 9 about the apparent underlying philosophy that Federal Government participation in the provision of family planning services be ultimately limited to welfare clientele. Such an approach attempts to walk a highly tenuous and perilous tightrope between the need for services for those who cannot afford them, on the one hand, and, on the other, the great concern that exists in minority groups and other poverty communities that some people have a hidden agenda for Federal involvement in the provision of family planning services—namely, “family planning is fine for the black, the brown, and the poor, who already drain too much of our economic resources through poverty programs, welfare payments and services, and other special programs.”

I categorically reject any such agenda—hidden or otherwise—and any such philosophy.

Although I agree that our primary obligation is to get quality services to those who can least afford them, I cannot endorse a policy

which identifies the major Federal family planning effort with the elimination of poverty and the public assistance program. I recognize that these sorts of distinctions are not easily made. In many respects it is a question of tone and program emphasis. But the underlying point is of critical importance, and we must not lose sight of it merely because it is a complicated problem not susceptible to facile resolution.

I think the administration's proposal raises these and other very serious questions, but at the same time I am hopeful that through these hearings and through attempts to accommodate our disparate positions, it may be possible to work out legislation which the administration will be willing to accept extending title X of the Public Health Service Act.

Our witnesses this morning are Dr. Henry Simmons, Deputy Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare; accompanied by Dr. Louis Hellman, Deputy Assistant Secretary for Population Affairs; Dr. Carl Shultz, Director, Office of Population Affairs; Dr. Philip Corfman, Director, Center for Population Research, National Institute of Child Health and Human Development, National Institutes of Health; and Mr. Walter Bogan, Director, Office of Environmental Education, Office of Education.

I welcome each of you to the hearing. I understand that you have a memorandum to place in the record.

STATEMENT OF DR. HENRY SIMMONS, DEPUTY ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DR. LOUIS HELLMAN, DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS; DR. CARL SHULTZ, DIRECTOR, OFFICE OF POPULATION AFFAIRS; DR. PHILIP CORFMAN, DIRECTOR, CENTER FOR POPULATION RESEARCH, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, NATIONAL INSTITUTES OF HEALTH; AND WALTER BOGAN, DIRECTOR, OFFICE OF ENVIRONMENTAL EDUCATION, OFFICE OF EDUCATION

Dr. SIMMONS. Yes, we do. Thank you, Mr. Chairman.

We would like to enter for the record the following statement:

We understand that a suggestion has been made to the Subcommittee on Human Resources which is currently holding hearings on S. 1708 that section 1008 of title X which prohibits abortion as a means of family planning be strengthened to specifically prohibit research on abortifacient drugs. We feel that this prohibition, if enforced precisely, would seriously damage much research at the NIH simply because many important drugs have an abortifacient effect in humans and animals. Examples include most of the effective drugs against cancer (antimetabolites, alkylating agents, and certain antibiotics), the ergot alkaloids (some of which are effective against headache), a major class of antibacterial agents (tetracycline), and prostaglandins (which show promise in treatment of hypertension, asthma, and duodenal ulcer).

We would enter that for the record, Mr. Chairman, and we are prepared to answer whatever questions you might have.

[The information referred to and subsequently supplied follows:]

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH

TO : Deputy Assistant Secretary for Health, DHEW DATE: May 22, 1973

FROM : Acting Director, NIH

SUBJECT: The Suggested Prohibition of Research on Abortifacient Drugs

The 1971 DHEW Appropriations Act included the statement that "The Committee of Conference is agreed that, in population research, the prohibition in Title X of abortion as a method of family planning should not be construed so as to prevent scientific research into the causes of abortion and its effects." NIH has adhered to this ruling.

We understand that a suggestion has been made to the Subcommittee of Human Resources which is currently holding Hearings on S.1708 that this prohibition be strengthened specifically to prohibit research on abortifacient drugs. We feel that this prohibition, if enforced precisely, would seriously damage much research at the NIH simply because many important drugs have an abortifacient effect in humans and animals. Examples include most of the effective drugs against cancer (antimetabolites, alkylating agents, and certain antibiotics), the ergot alkaloids (some of which are effective against headache), a major class of antibacterial agents (tetracycline), and prostaglandins (which show promise in treatment of hypertension, asthma, and duodenal ulcer).


John F. Sherman, M.D.

Senator CRANSTON. All of the questions I have will be given to you as a group, and whoever deems it appropriate may answer.

First let me say that while I do believe that family planning services are well within the definition of preventive health services, and should be made available under all health programs supported by the Federal Government, I do not approve of a total reliance on medicaid and title IV-A, as you suggest, as the Federal Government's means of fulfilling its commitment to make these services available.

However, I do think these two third-party payment programs have an important role in providing services to the 6.6 million women HEW estimates want services and are unable to afford them. This is one of the reasons I feel the position of the Assistant Secretary for Population Affairs should be in the Office of the Secretary rather than under the Office of the Assistant Secretary of Health and Scientific Affairs.

The family planning head must be able to coordinate programs under the Social and Rehabilitation Service (SRS) authorities as well as under traditional Public Health Service (PHS) Act authorities. The administration's suggestion that even more emphasis be placed on SRS seems to me a strong argument for placing the Assistant Secretary in the Office of the Secretary.

How do you see the present Deputy Assistant Secretary position functioning vis-a-vis expanded SRS programs bearing the major share of family planning activities if he remains within the Office of the Assistant Secretary for Health and Scientific Affairs who has no direct responsibility over SRS?

Dr. SIMMONS Mr. Chairman, two answers to that question. First of all, both we in the Office of the Secretary and the present incumbent, Dr. Hellman, feel that the present arrangement is satisfactory and will enable a viable, vigorous, and healthy effort in population affairs.

The problem of responsibility in Social Security Act programs and insurance and payment mechanisms is currently under study by the Secretary of HEW and the Assistant Secretary of Health and the heads of the other two agencies.

Senator CRANSTON. When will that study be presented?

Dr. SIMMONS. That has already started, and we think within the next 3 or 4 weeks the recommendation will be in on that. We expect in HEW to arrive at a satisfactory resolution, so the appropriate people have input on questions of insurance coverage and what is paid for.

Senator CRANSTON. We really need that before we can evaluate your proposal.

Dr. SIMMONS. Already, as you know, the Assistant Secretary of Health has been delegated the policy responsibility and ability to give policy input into those two programs.

Senator CRANSTON. How does the Deputy Assistant Secretary for Population Affairs impact on the whole HEW legislative picture?

Dr. SIMMONS. He would have the kind of input appropriate to his area of concern, as he has today.

Senator CRANSTON. But he has no direct line responsibility over SRS, does he?

Dr. SIMMONS. No, he does not, but what is being anticipated by the Secretary of HEW is to create a mechanism whereby the Assistant Secretary of Health and his designated associates will be able to have adequate health input in the development of Federal health insurance programs.

Senator CRANSTON. Can that report be made available to us by June 15?

Dr. SIMMONS. I cannot say the exact date, Mr. Chairman, but I am sure that a report will be made available to this committee.

Senator CRANSTON. Could you explore, after this hearing, when it will be made available, and let us know?

Dr. SIMMONS. Yes.

[Dr. Simmons subsequently advised the subcommittee that the study referred to is not yet available.]

Senator CRANSTON. Dr. Hellman, would you explain your various departmentwide coordination responsibilities. For example, your office is supposed to have a coordinating authority over FDA's regulatory functions relative to contraceptive drugs and devices. How exactly does that work? Do you encounter difficulties which would be ameliorated by stronger or additional legislative authorities?

Dr. HELLMAN. No, sir, I have a weekly staff meeting. At that staff meeting a man from FDA attends. I am often called on for advice by FDA. I think we have splendid cooperation there.

Senator CRANSTON. As far as FDA is concerned, you just call upon them for advice, but you have no actual coordinating authority?

Dr. HELLMAN. No. I have coordinating and line authority over FDA.

Dr. SIMMONS. There is no question about that, Mr. Chairman. Dr. Edwards has line authority over the five health agencies, and Dr. Hellman as deputy assistant secretary in this position would have that same line authority as appropriate.

Senator CRANSTON. Does he in fact have that authority?

Dr. SIMMONS. He has it right now.

Senator CRANSTON. Apart from what is to me an apparent need for an increase in funding levels and more program visibility, would you care to give some opinions as to how the population research program could be strengthened? Have you encountered any difficulties with the present administrative arrangements in that regard?

Dr. HELLMAN. I have encountered no administrative difficulties either in coordination or exercising line authority with the Center for Population Research or the National Institute of Child Health and Human Development. As a matter of fact, our relationship has been extremely close.

Dr. Corfman comes to my weekly staff meeting. We are not in daily contact but perhaps communicate two or three times a week. The policies that he sets are discussed with me and changed as I think they ought to be changed, so that I have no problem there.

Senator CRANSTON. Does Dr. Corfman serve as a special assistant to you? It was indicated that would be the case during consideration of the Tydings bill.

Dr. HELLMAN. I do not remember that Dr. Corfman was specially designated as a special assistant. But he is the Director of the Center, and I have line authority over Dr. Corfman's activity.

Senator CRANSTON. Does he serve as a special assistant to you?

Dr. HELLMAN. Yes. I would say I have never classified him as that, but he certainly prepares things as an assistant would.

Senator CRANSTON. There was a letter stating that he would be designated as a special assistant.

Dr. HELLMAN. He is not so designated.

Senator CRANSTON. Do you know why that is?

Dr. HELLMAN. I see no reason for that designation.

Senator CRANSTON. Why was the letter written saying that would be done?

Dr. HELLMAN. I do not remember the letter. Oh, you are referring to the two special assistants; not Dr. Corfman.

That was the plan originated in 1970 actually as I was coming down here and which we were to have two special assistants, one to act as liaison between the National Institutes of Health, Dr. Marston's staff, and me, and one to act in the Health Services and Mental Health Administration as liaison between Dr. English's staff and me.

When I got down here, in order to act quickly, we appointed consultants rather than special assistants. We had a trial period of using these consultants. As you remember, I had Dr. Sheldon Segal and Dr. Moye Freyman.

This appeared to be an administratively cumbersome procedure in that it interspersed somebody between me and my agency director. I did not need anybody interspersed there, nor did I need anybody to talk for me to Dr. Marston or Dr. English. I could do this myself. So that we did not follow through on that procedure.

The letter was a letter of intent, sir, and I do not think it was ever meant to cast my administration in concrete.

Senator CRANSTON. The letter was from Creed Black, dated March 17, 1970, to Senator Eagleton, and the letter states as follows:

[The letter referred to and subsequently supplied follows:]

THE UNDER SECRETARY OF HEALTH, EDUCATION,
AND WELFARE,
Washington, D.C., March 17, 1970.

HON. THOMAS EAGLETON,
U.S. Senate,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR EAGLETON: Roger Egeberg and I appreciated the opportunity to meet with you last week. As we indicated to you then, the Department is eager to proceed with the plan this administration has developed to increase the productivity of population research, particularly in the area of contraceptive development, and to expedite the delivery of family planning services to those who want but cannot afford them.

We recognize that the committee has reason to be impatient with the Department because of a history of unfulfilled promises. It is because we share this impatience and are interested in results that the Secretary has appointed Dr. Louis M. Hellman as Deputy Assistant Secretary for Population Affairs.

In collaboration with the operating agencies, Dr. Hellman has worked out a new organizational plan which has the full support of the Secretary and Dr. Egeberg. Briefly, it provides that the responsibility and authority for all the Department's programs in population and family planning will be centered in Dr. Hellman's office. Some of the specific features of the plan of interest to the committee are these:

Dr. Hellman will have line authority over both the research program of the Center for Population Research and the services program of the National Center for Family Planning Services.

This authority will be exercised through two officials of his selection who will have dual appointments. One will be Assistant Director of NIH for Population Research. The other will be Assistant Administrator of HSMHA for Family Planning Services. Both will also serve as special assistants to Dr. Hellman.

In addition, Dr. Hellman will have line authority over other activities in the Department which relate to the population field, such as the Food and Drug Administration's work with oral contraceptives.

The budget items for population activities would be assembled as a special category within the Department's budget presentation and would be defended by the Deputy Assistant Secretary for Population Affairs as the first individual health item to be considered immediately following the testimony of the Assistant Secretary for Health and Scientific Affairs.

With line authority, Dr. Hellman will of course have the staff resources of both the research and service centers at his disposal. In addition, however, he also plans to strengthen the staffing of his immediate office.

As you know, Dr. Hellman has been spending several days a month in the Department even though he will not join us on a full-time basis until May 1. He has had numerous discussions of his plans and goals with the heads of the operating agencies. They have agreed in principle to the organizational structure outlined here and are working with him to move forward rapidly.

Dr. Egeberg and Dr. Hellman both believe that valuable time would be lost by stopping now to consolidate both research and services in a single center as proposed in S. 2108. They are convinced that the administrative problems resulting from the kind of reorganization would inevitably slow progress toward the goals this Department shares with your committee.

As Dr. Egeberg told you so forcefully, however, he and the Secretary and Dr. Hellman are all committed to getting results. If the organizational plan they now favor is found inadequate, you may be sure that they will not hesitate to say so and work with the committee in trying to find a better one.

In closing, I should explain that I am writing you because Secretary Finch is ill and Dr. Egeberg is out of the country. I assure you and the committee, however, that I speak for them on this matter. If there are further questions about the Department's plans, we would be glad to discuss them with you.

Meanwhile, thank you on behalf of the Department for the opportunity you have given us to share with you our plan for progress in the population field.

Sincerely,

CREED C. BLACK,
Assistant Secretary for Legislation.

Dr. HELLMAN. Yes, sir, that was the plan. As I have tried to explain to you, that was an administratively cumbersome and not very effective way to run my office, because it interspersed somebody between me and the people I directed.

Senator CRANSTON. I am just baffled by the fact that the letter was written stating that would happen.

Are you still holding to your 5-year plan strategy for the conduct of research? For example, will you possibly have to drop one successful approach in favor of another because of lack of funds?

Dr. HELLMAN. No, sir, I would rather have Dr. Corfman talk about the strategy, but we are not going to drop any program at the present time.

Senator CRANSTON. Good. I do understand—could you shed any light on this—the Department of Health, Education, and Welfare was considering dropping its strategy and support for the centers in order to create funds for individual research, although that program has been a great success. Has that idea been dropped?

Dr. HELLMAN. Dr. Corfman.

Dr. CORFMAN. That was an inaccurate report of what occurred at the meeting, Senator Cranston. I never said at the meeting that we intended to drop our centers program. We intended to keep it together.

The amount of money we expect to spend for 1974 for the centers will be the same as in 1973.

Dr. HELLMAN. We have seven centers now. The number has increased each year, although not as quickly as we would have liked.

Senator CRANSTON. How many dollars are we talking about?

Dr. HELLMAN. \$2.5 million.

Senator CRANSTON. Is that the amount for 1974?

Dr. HELLMAN. Yes, sir.

Senator CRANSTON. It is standing at the 1973 figure in 1974?

Dr. HELLMAN. Same figure.

Dr. CORFMAN. That is just a projected figure. It depends on the applications we get and how they are reviewed. So far our centers program has not been compromised by the flattening in our budget.

Senator CRANSTON. I understand the Department of Health, Education, and Welfare is proposing to dismantle the Health Services and Mental Health Administration. I am concerned about the administration of the family planning funds. What is going to happen to the National Center for Family Planning Services? Is it going to continue?

Dr. SIMMONS. That is currently part of the reorganization, Mr. Chairman. As you know—and those decisions are being made right now—we plan to have, whatever the final form of the organization, a healthy family-planning effort in the Federal Government in HEW.

Dr. HELLMAN. I have heard no indication that the Center is going to be disbanded, Senator Cranston.

Senator CRANSTON. Is that going to be submitted for legislative action?

Dr. SIMMONS. No; it is administrative. It is within the authority of the Secretary of HEW.

Senator CRANSTON. When will there be a decision on the exact status of the Center in that reorganization?

Dr. SIMMONS. We are hoping to have many decisions made by July 1, and then there will be a more detailed decision that will take a number of months after that.

Senator CRANSTON. I would appreciate it if you would let the Secretary know we are particularly interested in that, and let us know the time action will be taken.

[Dr. Simmons subsequently advised the subcommittee that the details of the reorganization are still not determined.]

Senator CRANSTON. Will the Center have a line relationship to the Deputy Assistant Secretary for Population Affairs?

Dr. SIMMONS. The detail of that whole reorganization is still not determined, Mr. Chairman. We are trying to find a most effective way to spend the Federal health dollar to help the most people.

Senator CRANSTON. If you would answer that clearly for the record when you can answer it.

[Dr. Simmons subsequently advised the subcommittee that the details of the reorganization are still not determined.]

Senator CRANSTON. Moving on to matters of the numbers of individuals served, current HEW figures indicate that 1,959,000 patients are served in organized programs and 1.2 million are served by private physicians. How many persons are served by title X grants?

Dr. SIMMONS. In the current year it is 1.7 million, Mr. Chairman.

Senator CRANSTON. What is the funding level derived from title X authorizations now?

Dr. SIMMONS. At the present time it is \$79.5 million for services project grants.

Senator CRANSTON. How many persons are served by project grants authorized by title V of the Social Security Act?

Dr. SIMMONS. About 300,000.

Senator CRANSTON. Could you submit that for the record?

Dr. SIMMONS. Yes, we will.

[The following information was subsequently supplied by Dr. Simmons.]

Project grants authorized by title V of the Social Security Act served about 300,000 individuals during fiscal year 1973.

Senator CRANSTON. What funding level do you attribute to title V project grant sources?

Dr. SHULTZ. Senator, in the current fiscal year approximately \$19 million is attributable to title V project grants for family planning services. In addition to that there is about \$4.5 million of maternity and infant care project grant money which is associated with the provision of family planning services.

Senator CRANSTON. How many persons are served by programs now supported by OEO?

Dr. SHULTZ. It is estimated that approximately 250,000 persons are now served by OEO projects.

Senator CRANSTON. What funding level is attributed to these OEO programs?

Dr. SHULTZ. Approximately \$15 million.

Senator CRANSTON. The administration proposes not to extend title V project grants and has announced its intention of terminating OEO; \$15 million of the \$122 million requested for family planning services projects in fiscal year 1974 is explained as covering transferred OEO programs.

How many patients do you contemplate organized programs can serve with this total Federal allocation of \$122 million for organized programs in fiscal year 1974?

Dr. SHULTZ. Our estimate is that this would provide services to 1.9 million individuals in organized programs.

Senator CRANSTON. Dr. Simmons, in your prepared statement you said that the 720 counties shown to be without organized family planning services are mainly in rural areas and contain less than 10 percent of the women who might need subsidized services. Do you believe medicaid or title IV-A is capable of providing services to the 10 percent in these areas?

Dr. SIMMONS. We think so, yes, Mr. Chairman.

Senator CRANSTON. Do you have any statistics showing the effectiveness of medicaid or title IV-A as a means of reaching women in these areas? While your statement reports that 90 percent of the counties have some form of organized family planning services, do you have any reports that indicate the degree of accessibility of these services to the individuals in the target group?

Dr. SIMMONS. In those counties?

Senator CRANSTON. Yes.

Dr. SIMMONS. No, we do not. We do know many of those people are within range of an adjoining county that would really be in their service area. Many of those counties which currently do not have a facility within them have a population so small that the program would not be economically viable. Some of these counties have private physicians who could provide family planning services.

Senator CRANSTON. In your prepared statement you say that 2 million low-income women are served by organized programs and 1.2 million by private physicians. Why do you feel the goal of reaching 6.6 million women by 1976 can best be achieved by expanding the program in the private physician sector, given the comparative low achievement record to date?

Dr. SIMMONS. First of all, I do not think of that as a low achievement record. I think that is a very substantial number of people.

Second, the 6.6 million figure I am not sure is an accurate one. It is a planning figure and projection, which is probably going to change quite significantly.

Third, the Federal funds we are talking about would be available to pay for care in a private physician's office or in the clinics that have been established through this program.

Senator CRANSTON. We will get into this also a bit later.

You also reported that the proportion of women served by private physicians is expected to increase during the next 3 years as a result of several factors. Among them were: First, removal of remaining legal and administrative barriers to family planning services.

What exactly are these barriers, and how are they being removed?

Dr. HELLMAN. There were previously barriers in regard to eligibility for services that made it much easier to use project grant money than to utilize medicaid or title IV.

There have been changes in eligibility, and we have the SRS people here who will detail those for you if you wish.

Also there are, in response to the act of Congress in 1972, amendments to the Social Security Act that are changing matching of both medicaid and title IV, so that title IV has a 90-percent match from a 75-percent match, and medicaid changes from a variable match to a 90-percent all the time.

There is indication, and certainly the center will give much assistance to our projects in helping them devise systems for collection of medicaid money so that I think many of the barriers can disappear. Whether they will or not we have yet to prove. We do not have proof at the present time.

Senator CRANSTON. Would you please supply those details that you referred to for the record?

Dr. HELLMAN. Yes, sir.

[The information subsequently supplied for the record, follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service
[48 CFR Part 221]

FAMILIES, CHILDREN, AGED, BLIND, OR DISABLED INDIVIDUALS

Service Programs

Notice is hereby given that the regulations set forth in tentative form below are proposed by the Administrator, Social and Rehabilitation Service, with the approval of the Secretary of Health, Education, and Welfare.

Notice of proposed rulemaking was published in the *FEDERAL REGISTER* on February 16, 1973 (38 FR 4808).

Final regulations responsive to comments received were published in the *FEDERAL REGISTER* on May 1, 1973 (38 FR 10782), with an effective date of July 1, 1973. An amendment clarifying several provisions was published on June 1, 1973 (38 FR 14373).

Public Law 93-66 signed by the President on July 9, 1973, postponed the effective date until November 1, 1973. Notice of this postponement was published in the *FEDERAL REGISTER* on July 25, 1973 (38 FR 19911).

The new proposals would amend the regulations published on May 1, 1973 and June 1, 1973 to:

1. Require States to establish, under the adult services program, a plan for deinstitutionalization and prevention of institutionalization of individuals through the provision of defined services (§ 221.5(a)).

2. Broaden the coverage of potential recipients, consistent with the deduction for work-related expenses enjoyed by recipients, by defining the income limit as \$60 plus 150 percent (225 percent in relation to day care) of the payment standard (previously \$30) (§ 221.6(a)(3)(i)).

3. Permit an additional income disregard for the mentally retarded, with the amount to be established by each State; (§ 221.6(a)(3)(iii)).

4. Broaden the coverage (for family planning services) to include any female of childbearing age who meets financial eligibility requirements; (§ 221.6(a)(3)(vii)).

5. Allow 6 months (instead of 3) from the effective date of the final regulations for redetermination of eligibility of all current recipients of services; (§ 221.7(b)).

6. Remove the cumbersome aspects of the assets test for determination of potential recipients, although States must continue to consider available resources in determining whether families and individuals are likely to become applicants for or recipients of financial assistance within 6 months;

7. Add the goal of strengthening family life (§ 221.5(a)(3)), under which States may provide family planning services; and other services including day care, to prevent child abuse and neglect (§ 221.9(b)(3));

8. Expand the definition of health-related services to encompass those necessary to a program of active treatment for alcoholics and drug addicts; (§ 221.9(b)(9)).

9. Expand the definition of legal services to include those required to establish paternity of children born out of wedlock, obtain child support payments, and legally adopt a child; (§ 221.9(b)(14)).

10. Add a new defined service, Special services for the mentally retarded; (§ 221.9(b)(19)).

11. Provide Federal financial participation for appropriate medical services necessary for active treatment of drug addicts and alcoholics, together with medical treatment required for services to the mentally retarded, provided that any other public and private sources are utilized first; (§ 221.53(i)).

12. Incorporate the statutory language concerning Federal sharing in services to children in foster care; (§ 221.55(d)(5)).

The proposed regulations do not affect current provisions in Part 220 applicable to the work incentive program (WIN) and to child welfare services (CWS). Amendments to those portions of Part 220 will be published separately.

Prior to the adoption of the proposed regulations, consideration will be given to any comments, suggestions, or objections thereto which are received in writing by the Administrator, Social and Rehabilitation Service, Department of Health, Education, and Welfare, 330 Independence Avenue SW., Washington, D.C. 20201, on or before October 10, 1973. Comments received will be available for public inspection in Room 5224 of the Department's offices at 330 C Street SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (area code 202-662-4451).

(Sec. 1102, 48 Stat. 647 (48 U.S.C. 1302) (Catalog of Federal Domestic Assistance No. 12794, Public Assistance—Social Services))

Dated September 5, 1973.

JAMES S. DEWEY, Jr.,
Administrator, Social and
Rehabilitation Service.

Approved September 5, 1973.

FRANK CARLUCCI,
Acting Secretary.

Part 221, Chapter II, Title 45 of the Code of Federal Regulations is amended as set forth below:

1. Section 221.2 is amended to revise paragraph (c) as follows:

§ 221.2 Organization and administration.

(c) Opportunity to present views.—There must be an opportunity for recipients of services to present their views about the services program. The State may permit such opportunity to be either oral or in writing.

2. Section 221.5 is revised as follows:

§ 221.5 Statutory requirements for services.

(a) In order to carry out the statutory requirements under the act with respect to family services and adult services programs, and in order to be eligible for 75 percent Federal financial participation in the costs of providing services, including the determination of eligibility for services, the State must, under the family services program, provide to appropriate members of the AFDC assistance unit the mandatory services and those optional services the State elects to include in the State plan, and must, under the Adult Services program, establish a plan for deinstitutionalization and preventing institutionalization of individuals, and include in the State plan those defined adult services which the State considers necessary to achieve that objective.

(b) (1) For the family services program, the mandatory services are family planning services, foster-care services for children, and protective services for children. The optional services are day-care services for children, educational services, employment services (non-WIN), health-related services, homemaker services, home management and other functional educational services, housing improvement services, legal services, transportation services and special services for the mentally retarded.

(2) For the adult services program, the defined services are chore services, day-care services for adults, educational services, employment services, family planning services, foster-care services for adults, health-related services, home delivered or congregate meals, homemaker services, home management and other functional educational services, housing improvement services, legal services protective services for adults, special services for the blind, transportation services and special services for the mentally retarded.

3. Section 221.6(a)(3) is amended by revising subdivisions (i) and (ii), redesignating subdivisions (iii), (iv), and (v) as (iv), (v), and (vi) and adding new subdivisions (iii) and (vii) as follows:

§ 221.6 Services to additional families and individuals.

(a) (3) (i) With respect to title IV-A, have gross monthly income which after deducting \$60, (A) does not exceed 150 percent of the State's financial assistance payment standard; or (B) with respect to eligibility for day-care services, does not exceed the maximum allowable under the State's schedule of fees to be paid for such services by otherwise eligible families, as contained in the State's approved plan; or

(ii) With respect to titles I, X, XIV, or XVI, have gross monthly income which does not exceed 150 percent of the combined total of the supplementary security income benefit level provided for under title XVI of the Act (as amended by Public Law 92-603) and the State supplementary benefit level, if any (in

the case of Puerto Rico, the Virgin Islands, and Guam, 180 percent of the financial assistance payment standard);

(iii) Notwithstanding the provisions of paragraph (c)(2)(i) and (ii), of this section, with respect to an otherwise eligible mentally retarded individual as defined in paragraph (c)(3)(v) of this section, the State plan shall provide for an additional deduction from gross monthly income in order to recognize the unique financial burden associated with a mentally retarded individual.

(iv) (A) In the case of eligibility under title IV-A, have a specific problem or problems which are susceptible to correction of amelioration through provisions of services and which will lead to dependence on financial assistance under title IV-A within 6 months if not corrected or ameliorated; or

(B) In the case of eligibility under title I, X, XIV, or XVI, have a specific problem or problems which are susceptible to correction or amelioration through provisions of services and which will lead to dependence on financial assistance under such title, or medical assistance, within 6 months if not corrected or ameliorated; and who are

(1) At least 64½ years of age for linkage to title I or title XVI with respect to the aged;

(2) Experiencing serious, progressive deterioration of sight that, as substantiated by medical opinion, is likely to reach the level of the State agency's definition of blindness within 6 months, for linkage to title X, or title XVI with respect to the blind; or

(3) According to licensed physician's opinion as approved by the State agency, experiencing a physical or mental condition which is likely to result within 6 months in permanent and total disability, for linkage to title XIV, or title XVI with respect to the disabled.

(v) Notwithstanding the provisions of this subparagraph (3) or § 221.7(b)(1), an eligible mentally retarded individual may for the period July 1, 1973, through December 31, 1973, be considered by the State as eligible for services for so much of such period as the mentally retarded individual continues to meet the eligibility requirements of § 222.55(a)(2) of this chapter, as previously in effect. "Mentally retarded individual" means an individual, not psychotic, who, according to a licensed physician's opinion, is so mentally retarded from infancy or before reaching 18 years of age that he is incapable of managing himself and his affairs independently, with ordinary prudence, or of being taught to do so, and who requires supervision, control, and care, for his own welfare, or for the welfare of others, or for the welfare of the community.

(vi) Notwithstanding the provisions of this subparagraph (3), or § 221.7(b)(1), children of migrant workers may be considered by the State to be eligible for day-care services through December 31, 1973, on the basis of the provisions of part 220 as previously in effect.

(vii) Notwithstanding the provisions of this subparagraph (3), or § 221.8(a),

any female of childbearing age who requests family planning services may be considered eligible to receive such services as defined in § 221.9(b)(8)(i); provided such individual has gross monthly income which, after deducting \$60, does not exceed 150 percent of the State's financial assistance payment standard under title IV-A for one adult plus one child, or, if she is part of a family unit, then the applicable payment standard for such family unit plus one child.

(4) Aged, blind, or disabled persons who are likely to become applicants for or recipients of financial assistance under the State plan within 6 months as evidenced by the fact that they are currently eligible for medical assistance as medically needy individuals under the State's title XIX plan.

§ 221.7 [Amended]

4. Section 221.7(b)(1) is amended by changing the time period from three months to six months.

5. Section 221.8 is amended to add a new paragraph (a)(3) as follows:

§ 221.8. Program control and coordination.

(a) . . .

(3) *Strengthening family life goal.*—In the case of all recipients of financial assistance under the family program, to strengthen family life by providing (i) family planning services and (ii) such defined family services in the State plan as are necessary to prevent neglect or abuse of a child who has been identified as likely to become neglected or abused as a result of home conditions which seriously threaten the child physically or emotionally.

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6. In § 221.9, paragraphs (b)(3), (b)(9), and (b)(14) are revised and a new paragraph (b)(19) is added as follows:

§ 221.9. Definitions of services.

(a) This section contains definitions of all mandatory and optional services under the family services program and the defined services under the adult services program (see §§ 221.5 and 221.6).

(b)(1) *Chore services.*—This means the performance of household tasks, essential shopping, simple household repairs, and other light work necessary to enable an individual to remain in his own home when he is unable to perform such tasks himself and they do not require the services of a trained homemaker or other specialist.

(2) *Day care services for adults.*—This means personal care during the day in a protective setting approved by the State or local agency.

(3) *Day care services for children.*—This means care of a child for a portion of the day, but less than 24 hours, in his own home by a responsible person, or outside his home in a day care facility. Such care must be for the purpose of enabling the caretaker relatives to participate in employment or training, or because of the death, continued absence from the home, or incapacity of the child's mother and the inability of any

member of such child's family to provide adequate and necessary care and supervision for such child. Day care may also be provided, when appropriate, for eligible children who are mentally retarded and to other recipients, to the extent necessary to accomplish the strengthening family life goal. In-home care must meet State agency standards, that as a minimum, include requirements with respect to: The responsible person's capacity and available time to properly care for children; minimum and maximum hours to be allowed per 24-hour day for such care; maximum number of children that may be cared for in the home at any one time; and proper feeding and health care of the children. Day care facilities used for the care of children must be licensed by the State or approved as meeting the standards for such licensing and day care facilities and services must comply with such standards as may be prescribed by the Secretary.

(4) *Educational services.*—This means helping individuals to secure educational training most appropriate to their capacities, from available community resources at no cost to the agency.

(5) *Employment services (son-WIN under title IV-A and for the blind or disabled).*—This means enabling appropriate individuals to secured paid employment or training leading to such employment, through vocational, educational, social, and psychological diagnostic assessments to determine potential for job training or employment; and through helping them to obtain vocational education or training at no cost to the agency.

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(9) *Health-related services.*—This means helping individuals and families to identify health needs and to secure needed health services available under medical, medicare, maternal and child health programs, handicapped children's programs or other agency health services programs and from other public or private agencies or providers of health services; planning, as appropriate, with the individual and health providers to help assure continuity of treatment and carrying out of health recommendations; helping such individual to secure admission to medical institutions and other health related facilities; and providing appropriate medical services necessary to a program of active treatment of individuals who are alcoholics or drug addicts.

(10) *Home delivered or congregate meals.*—This means the preparation and delivery of hot meals to an individual in his home or in a central dining facility as necessary to prevent institutionalization or malnutrition.

(11) *Homemaker services.*—(i) For family services this means care of individuals in their own homes, and helping individual caretaker relatives to achieve adequate household and family management, through the services of a trained and supervised homemaker.

(ii) For adult services this means care of individuals in their own homes, and helping individuals in maintaining,

strengthening, and safeguarding their functioning in the home through the services of a trained and supervised homemaker.

(12) *Home management and other functional educational services.*—This means formal or informal instruction and training in management of household budgets, maintenance and care of the home, preparation of food, nutrition, consumer education, childrearing, and health maintenance.

(13) *Housing improvement services.*—This means helping families and individuals to obtain or retain adequate housing. Housing and relocation costs, including construction, renovation or repair, moving of families or individuals, rent, deposits, and home purchase, may not be claimed as service costs.

(14) *Legal services.*—This means the services of a lawyer in solving legal problems of eligible individuals to the extent necessary to obtain or retain employment, establish paternity of children born out of wedlock, secure and collect child support payments and legally adopt a child. This does not apply to district attorneys or other public prosecuting attorneys, and excludes all other legal services, including fee generating cases, criminal cases, class actions, community organization, lobbying, and political action.

(15) *Protective services for adults.*—This means identifying and helping to correct hazardous living conditions or situations of an individual who is unable to protect or care for himself.

(16) *Protective services for children.*—This means responding to instances, and substantiating the evidence, of neglect, abuse, or exploitation of a child; helping parents recognize the causes thereof and strengthening through arrangement of one or more of the services included in the State plan) parental ability to provide acceptable care; or, if that is not possible, bringing the situation to the attention of appropriate courts or law enforcement agencies, and furnishing relevant data.

(17) *Special services for the blind.*—This means helping to alleviate the handicapping effects of blindness through: Training in mobility, personal care, home management, and communication skills; special aids and appliances; special counseling for caretakers of blind children and adults; and help in securing talking-book machines.

(18) *Transportation services.*—This means transportation necessary to travel to and from community facilities or resources for receipt of mandatory or optional services.

(19) *Special services for the mentally*

retarded.—This means helping to alleviate the handicapping effect of mental retardation through: evaluation of the individual through necessary medical and psychological services; counseling with parents or caretaker relatives of the retarded individual; sheltered employment; day care appropriate to the needs of retarded individuals; and special training for self-care.

§ 221.30 (Amended)

7. In § 221.30, the date in the second sentence is changed from July 1, 1973 to November 1, 1973.

8. Section 221.52 is amended by redesignating paragraph (n) as (o) and adding a new paragraph (n) to read as follows:

§ 221.52 Expenditures for which Federal financial participation is available.

(n) When providing meals is an integral part of day care services, costs of food when limited to snacks and light meals, and not otherwise available under any public program.

9. Section 221.53(i) is revised as set forth below:

§ 221.53 Expenditures for which Federal financial participation is not available.

(i) Medical, mental health, or remedial care or services, except when they are:

(1) Part of the family planning services under title IV-A, including medical services or supplies for family planning purposes or

(2) Medical examinations which are required for admission to child-care facilities or for persons caring for children under agency auspices (but only to the extent not otherwise available from Medicaid, Medicare, or other public or private sources including insurance or other resources); or

(3) Appropriate medical services necessary to a program of active treatment of individuals who are alcoholics or drug addicts (but only to the extent not otherwise available from Medicaid, Medicare, or other public or private sources including insurance or other resources); or

(4) Appropriate medical or psychological services necessary to evaluation of a mentally retarded individual as provided in § 221.9(b)(19) (but only to the extent not otherwise available from Medicaid, Medicare, or other public or private sources including insurance or other resources).

10. Section 221.55(d) is revised to read as follows:

§ 221.55 Limitations on total amount of Federal funds payable to States for services.

(d) Not more than 10 percent of the Federal funds shall be paid with respect to expenditures in providing services under title IV-A to families or to individuals (eligible for services) who are not recipients of aid or assistance under State plans approved under such titles, or applicants for such aid or assistance, except that this limitation does not apply to the following services provided to eligible persons:

(1) Services provided to meet the needs of a child for personal care, protection, and supervision but only in the case of a child where the provision of such services is necessary in order to enable a member of such child's family to accept or continue in employment or to participate in training to prepare such member for employment, or because of the death, continued absence from home, or incapacity of the child's mother and the inability of any member of such child's family to provide adequate and necessary care and supervision for such child;

(2) Family planning services;

(3) Any services included in the approved State plan that are provided to an individual diagnosed as mentally retarded by a State mental retardation clinic or other agency or organization recognized by the State agency as competent to make such diagnoses, or by a licensed physician, but only if such services are needed for such individual by reason of his condition of being mentally retarded;

(4) Any services included in the approved State plan provided to an individual who has been certified as a drug addict by the director of a drug abuse treatment program licensed by the State, or to an individual who has been diagnosed by a licensed physician as an alcoholic or drug addict, but only if such services are needed by such individual as part of a program of active treatment of his condition as a drug addict or an alcoholic; and

(5) Services provided to a child who is under foster care in a foster family home (as defined in section 406 of the Social Security Act) or in a child-care institution (as defined in such section), or while awaiting placement in such a home or institution, but only if such services are needed by such child because he is under foster care.

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Senator CRANSTON. The second factor referred to is increased referrals of patients to private physicians by organized programs. Why do you expect organized programs to increase their referrals to private physicians?

Dr. HELLMAN. I think in many of the organized programs we have patients who can pay, and we have private physicians who are now willing to accept these patients.

We were surprised, Senator, at the extent of activity of the private physicians in our survey.

The training in medical schools has changed considerably in regard to family planning. All medical students have some family planning training, certainly all students of obstetrics and gynecology have extensive training. So that even in center city areas there seem to be more physicians who are interested in the family planning activities than there were say 5 years ago.

Senator CRANSTON. The third factor mentioned was third party insurance. Do you have statistics on coverage of family planning services in private third party health insurance?

Dr. SIMMONS. No, we do not; not private. We have medicaid, medicare.

Senator CRANSTON. Is there any way of getting that?

Dr. SIMMONS. I will try.

Senator CRANSTON. I would appreciate it.

PRIVATE HEALTH INSURANCE

[Dr. Simmons subsequently advised the subcommittee that this information is currently not available.]

Senator CRANSTON. Do you have statistics on the current level of coverage by public third party insurance?

Dr. SHULTZ. We have acquired some information, and we are trying to gather additional information to make this more complete. It is difficult to estimate or even to report on how extensive the changes and coverage will be due to the new Social Security Act amendments of 1972.

It is anticipated that with the incentives contained in those amendments, and with alterations in funding overall, there will be a marked increase in third party reimbursement mechanisms being used both by private physicians and by projects as a source of financial support.

The regional offices have submitted some information, and even in the 2 weeks since the original hearings there is evidence of an increase in negotiated arrangements between statewide family planning agencies and the State medicaid agencies in obtaining payments or establishing payment arrangements. We are dealing with a dynamic situation which appears to be moving in a favorable direction.

Senator CRANSTON. Do you have firm indications of increases in either the public or private sectors that you feel are clear commitments to expand coverage to family planning services?

Dr. SIMMONS. Mr. Chairman, the fact that the States are already moving to take advantage of the Social Security Amendments which have just been passed is one indication.

We have every reason to believe that the intent of Congress will in fact be carried out, that States will expand these programs under the medicaid program, and that the States will take advantage of what is now a fairly attractive kind of thing, 90 percent matching, mandatory provision of these services, and a penalty if they are not provided.

So we think all that put together bodes well.

Senator CRANSTON. Have new regulations been issued on implementation of H.R. 1 amendments to title XIX which provide 90 percent matching for family planning services?

Dr. SHULTZ. The regulations have not yet been published.

Senator CRANSTON. Are they in the works?

Dr. SHULTZ. Yes, sir.

Senator CRANSTON. When do you expect to get them out?

Dr. SHULTZ. They are currently under review in the Office of the Secretary, and an exact publication date cannot be given.

Senator CRANSTON. Could you find out and give us some indication when we could expect it?

Dr. SHULTZ. Yes, sir.

[The information subsequently supplied follows:]

Status of Title XIX Regulations

The regulations mandating provision of family planning services and providing 90 percent Federal matching for the cost of offering, arranging, and furnishing such services and supplies were published as proposed rule-making on Wednesday, June 13, 1973, in THE FEDERAL REGISTER.

CFR Part 249.10(b)(4)(iii) proposes that family planning services and supplies are any medically approved means, including diagnosis, treatment, drugs, supplies, devices, and related counseling which are furnished or prescribed by or under the supervision of a physician, for individuals of childbearing age (including minors who can be considered to be sexually active) for purposes of enabling such individuals freely to determine the number and spacing of their children. Federal financial participation is available at the rate of 90 percent of the sums expended on or after October 30, 1972, in offering, arranging, and furnishing such services and supplies.

CFR Part 200.120(c) proposes Federal financial participation is available at 90 percent for the compensation costs of personnel engaged in administering family planning services and supplies as defined in § 249.10(b)(4)(iii).

Senator CRANSTON. Dr. Simmons, your statement announced that the proper Federal role in family planning is the same as in health services delivery generally, that is, to reduce financial barriers to health services.

It seems to me that this is a much narrower concept of the Federal role than has been accepted in the past. In the past the Federal role has included the development of services capability where it was deficient.

The National Health Services Corps, the neighborhood health center, the family health center, migrant health centers, HMO's and the organized family planning program are some examples of application of this concept of the Federal role.

When did this narrower definition become accepted as HEW policy?

Dr. SIMMONS. Mr. Chairman, that may be misleading. We continue to believe that it is the Federal responsibility to mount demonstration efforts to provide a particular kind of care, to help those financially disadvantaged to pay for their care, and to open up access to care through removing financial barriers. These are Federal responsibilities.

Senator CRANSTON. In regard to migrant care, for example, if there is a demonstration project in an area where health care is inadequate, are we trying to proceed to see that it is made available on a continuing basis to meet the need?

Dr. SIMMONS. We are trying to proceed wherever possible to get the private sector to provide the necessary care for those who need it. As you know, there are areas where that is currently impossible. Migrant health in a number of areas is one of those. These areas which lack physicians and nursing care is another. Those we continue to maintain are a Federal responsibility.

Senator CRANSTON. Do you see a prospect that the private sector will take up that share of the load?

Dr. SIMMONS. No in some areas; no.

Senator CRANSTON. In migrant health, I am talking about.

Dr. SIMMONS. I am not familiar enough with migrant health to answer, Mr. Chairman.

Senator CRANSTON. Could that be looked into, for the record?

[The following information was subsequently supplied by Dr. Simmons:]

Migrant health programs have been extended through June 30, 1974.

Senator CRANSTON. I do not know, Dr. Simmons, whether you are familiar with a study recently completed by Macro Systems, Inc., for the Office of Assistant Secretary for Planning and Evaluation. It is titled "Strategies for Accommodating Ambulatory Care Projects Under Medicare and Medicaid." The study lists a number of reasons why the medicaid program is and has been a poor tool for the financing of preventive health services, and concludes that no more than 20 to 25 percent of the total cost of services can ever be expected to be forthcoming from medicaid even under the most ideal circumstances.

Even then the report concludes, and I quote: This "would require a carefully orchestrated blend of legislative regulatory and administrative action. The latter would be mainly in the form of large-scale technical assistance."

I would like to enter the summary of the study in the record ¹ and ask you, whether the sum of \$43 million for medicaid services, which is contained in your fiscal year 1974 budget is realistic in view of the conclusions of that study?

Isn't this \$43 million in the first year more than the goal which could ever be reached without a substantial change in that approach?

Dr. SIMMONS. That figure already has been modified. The new figure is \$30.6 million.

In regard to the Macro Report, the most I would say at this time is that we would agree that it will require proper development of regulations which we are planning to do. I do not think we can agree with all the conclusions of the Macro Report. I believe we have other consultant reports that would not reach that same conclusion which we could make available to the committee.

Senator CRANSTON. Turning to the administration's proposal to fund family planning services under section 314(e) of the Public Health Service Act, I have a distinct sense of *deja vu*. If you remember, as far back as 1966, the then Johnson administration was testifying in relation to proposed family planning legislation, and I quote:

It is our belief that family planning services can, on the whole, be best and most suitably provided within the framework of a broad health services program. In this regard may I refer to S. 3008, "Comprehensive Health Planning and Public Health Services Amendments of 1966".

Quoting further:

In the bill, S. 3008, the administration has proposed a basis reform in the provisions of the Public Health Service Act for grants for public health services, so as to stress the development of comprehensive public health services rather than the existing categorical approach authorized by existing legislation.

In summary, though we strongly support the basic objectives of S. 2993, we believe that our existing authority and those incorporated in S. 3008 will provide adequate authority and funds for the development of the family planning and other health services which are needed but which are not yet available in many communities. We therefore do not recommend enactment of S. 2993 at this time.

Faced with the skepticism of the Labor and Public Welfare Committee, then Assistant Secretary Lee added:

If in 1 year or 2 years we find through existing authorities an adequate number of programs and services did not develop, then we certainly would not be opposed to a categorical program in family planning.

In 1969 it turned out that despite administration expectations, following a decision not to have a categorical program, less than \$500,000 had in fact been allocated under section 314 (e), which had been presented to us as the preferred funding channel for family planning services.

In view of that relevant history, how can you really believe that the future of the program can best be served by being subsumed under this section?

Dr. SIMMONS. Mr. Chairman, it would be presumptuous of me to comment on why the particular stand was taken by another administration in 1966.

Senator CRANSTON. I am not really asking that. We have the same situation now.

Dr. SIMMONS. What I can say is that we are in a situation now in which adequate facilities are in place. We are in a position where Con-

¹ See appendix on p. 397.

gress has said through Public Law 92-603 that its intent is that these types of services of family planning be provided on the basis of need as part of the Federal-local effort, primarily through medicaid. That is the will of Congress.

We also feel that the sooner family planning becomes part of a broad health services program through health insurance and medicaid, we will have a healthier operation.

Given all these things together, we think the administration's proposal is a sound one and will allow what is already a successful program to continue and grow as appropriate.

Senator CRANSTON. Is the statistic correct, that two of the three individuals now being served are being served through grant programs?

Dr. SIMMONS. Yes.

Senator CRANSTON. Senator Javits, in introducing the administration's proposal with regard to section 314(e), cited the House report on the communicable disease control amendments of last year, which I would like to quote to you:

In each of its budget presentations each year since the enactment of Section 314(e), the Department of Health, Education and Welfare has earmarked specific amounts of the 314(e) fund request for specific programs for the coming year. In other words, the categorical grant approach has continued since the enactment of Public Law 89-749, except that instead of the Congress setting the categories, the categories have been set by the Department of HEW.

What guarantees do we have under proposals over the next 3 years that the funding for family planning services would continue at the level which we in Congress believe appropriate?

Dr. SIMMONS. There are a number of reasons why we feel that funding will continue at an adequate level.

One, project grants will continue; two, we are setting up two mechanisms for individuals to have access to either private or public care through the financial reimbursement mechanisms: (1) Medicaid and title IV-A already in place; and (2) National Health Insurance which we would propose would allow payment for this kind of service when enacted.

Senator CRANSTON. In view of the decentralization of grant programs, would you not expect considerable variation in priorities between the HEW regions in the allocation of 314(e) moneys under your proposal?

Dr. SHULTZ. The whole purpose of decentralization is to go in the direction of allowing the State and local area to determine the priorities. There would be variations, and these variations would be regarded as desirable.

It has proved very successful so far in decentralization under the current categorical project grant program to have local determination be the operative factor.

Dr. HELLMAN. Senator, estimates of needs were actually set up by the regional people under the current program. I think there is every reason to believe that both the States and the people in the States want family planning services. The situation is not the same as it was in 1966 or 1969.

I think we have an opportunity to try this approach. The Family Planning Act continues in force, there will be an annual report to the Congress, so that it is not a situation without a check.

Senator CRANSTON. Last year we heard very constructive testimony from representatives of both black and Chicano communities who voiced a concern that family planning services should be offered only in conjunction with the full array of other social and health services which had higher priority to members of these communities.

I have tried to address this concern in S. 1708 by requiring consumer participation in the decisionmaking process of organized programs, and by requiring that organized programs provide for coordination of family planning services with the provision of comprehensive health services.

If organized programs are not expanded, how can these two objectives be built into alternative approaches of providing the services as suggested by the administration, such as through medicaid and title IV-A of the Social Security Act?

Dr. SIMMONS. Mr. Chairman, as you know, the programs currently in place, these 2,300, do offer comprehensive services at the present time. In fact, family planning services programs are a significant factor in providing low-income women access to the total health care system.

As far as consumer participation is concerned, it is required by the current regulations governing the program.

Senator CRANSTON. How do we translate those approaches into the administration of the programs under the title that you propose to proceed under?

Dr. SIMMONS. I am not sure that I see any difficulty in it. My basic premise, the administration's basic premise, is that the current program will continue in the 2,300 counties currently covered and will provide services to most of the women who desire but cannot afford them.

We have a variety of funding mechanisms, some of which have been changed, so that they are even more attractive now than they have been in the past. The States have already indicated their desire for and acceptance of family planning as an important public service.

I am not sure that I see any difficulty created by the proposed changes in the administration.

Dr. SHULTZ. We have been informed that State advisory councils are being required by title XIX, and many more are already in existence.

Senator CRANSTON. That is somewhat different from direct involvement in local programs of the consumer. I wish you would explore this matter of how the consumer can have more of a voice in those, and submit it for the record.

Dr. SIMMONS. Mr. Chairman, I do not think under the various programs that we have been proposing to fund under 314(e) authority that we propose to change any of the program operating guidelines that are already in effect.

As a matter of fact, I think that would be the last thing we would want to do, because we would not want a discontinuity, and I am certainly unaware of any proposal to change those.

Senator CRANSTON. The question is how it is going to work under those other titles. I wish you would explore that as I requested a moment ago and submit that material for the record.

[The information subsequently supplied follows:]

Consumer Participation in Title XIX and IV-A Programs

A State level medical care advisory committee with consumer representation is a requirement under current regulations (Part 45 CFR 246.10). The medical care advisory committee must include members of consumers' groups including Title XIX recipients and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others.

The regulations provide that the medical care advisory committee will have adequate opportunity for meaningful participation in policy development and program administration, including the furtherance of recipient participation in the program of the agency. The regulations also provide that financial arrangements will be made where necessary to make possible the participation of recipients in the work of the committee.

Another State plan requirement under Title XIX (Title 1902 (a)(4)(B)) is for the training and effective use of sub-professional staff as community service aides. The regulations (45 CFR 225.2) provide that part-time or full-time employment be offered to persons of low income and, where applicable, to recipients of assistance. These subprofessionals could serve as family planning aides.

Under Title IV-A, there is no requirement that there be consumer participation in the decision-making process of organized programs for family planning.

Projects approved for funding by the National Center for Family Planning Services are required to have consumer participation. Therefore, any services provided by these projects would have consumer participation. Other sources that provide services would be either licensed or sources that otherwise meet State and Federal standards.

Senator CRANSTON. The administration has stated it proposes to base any expansion of family planning programs on services provided by private physicians reimbursed through medicaid or through title IV-A of the Social Security Act. A careful reading of the administration's testimony leads me to believe that after fiscal year 1974 you propose to phase out all project grant support. Is that correct?

Dr. SIMMONS. No, sir; that is not correct.

Senator CRANSTON. What is the plan in regard to project grants?

Dr. SIMMONS. We have not developed the most appropriate way to proceed after the next few years.

Senator CRANSTON. Beyond 1974?

Dr. SIMMONS. Right.

Senator CRANSTON. That is under study. The implications of everything that has been said up to this point are that project grants are finished. When can we have some clear-cut answer as to just what is proposed?

Dr. SIMMONS. As soon as we develop that information we will be happy to share it with the committee, Mr. Chairman.

The basic intent of the administration is to continue what is now a viable and very successful program. We may find a more effective way to continue it. If so, we will propose that way be adopted, and that determination has not yet been made.

Senator CRANSTON. When you said you would propose it, are you saying that any plans for programs affecting the future project grants will be submitted to Congress for its approval?

Dr. SIMMONS. If appropriate. There are some changes which can be made administratively. As I said, not knowing what that final decision would be, I cannot answer that question.

Senator CRANSTON. The question gets down to whether programs on the books and funds appropriated under the process of law will then be carried out and expanded.

Dr. SIMMONS. We intend to carry out the intent of the Congress.

Senator CRANSTON. Numerous witnesses testified 2 weeks ago that there are very serious limitations on the provision of family planning services to individuals in terms of eligibility under either medicaid or title IV-A. Could you comment on that?

Dr. SIMMONS. Mr. Chairman, we could answer those specific questions for the record. We feel that there will not be serious problems in that area.

Senator CRANSTON. Would you please do that.

Dr. SIMMONS. Yes.

[The information subsequently supplied follows:]

Eligibility Under Titles IV-A and XIX

Under Title IV-A, there are no limitations to the provision of family planning services to individuals receiving AFDC and other individuals eligible under the State's approved plan. Family planning services are to be offered to all individuals including sexually active minors. The proposed regulations for Titles IV-A and XIX establish a uniform method for determining the eligibility of former or potential recipients that will help States direct social services, including family planning, to the neediest of our population.

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Senator CRANSTON. Are there not also limitations in terms of the comprehensiveness of the services offered under medicaid?

Dr. SIMMONS. No; there are not. Mr. Chairman.

Senator CRANSTON. There was testimony that there was. Would you review that and submit detailed answers on this point.

Dr. SIMMONS. Yes.

[The information subsequently supplied follows:]

Comprehensiveness of Family Planning Services Under Medicaid

Relative to the comprehensiveness of family planning services under Title XIX, PL 92-603 makes provision of family planning services a mandate under State medical assistance programs for the categorically needy.

In proposed rulemaking, the Department has defined family planning services as any medically approved means, including diagnosis, treatment, drugs, supplies, devices and related counseling which are furnished or prescribed by or under the supervision of a physician, for individuals of childbearing age (including minors who can be considered to be sexually active) for purposes of enabling such individuals freely to determine the number and spacing of their children.

Medicaid's family planning services are available on a State-wide basis and not merely within a limited geographical area. These services can be provided in doctors' offices, clinics, and hospitals (inpatient and outpatient services), and in any other setting in which physician services are available.

Senator CRANSTON. To be more specific, in Alabama the AFDC payment standard is \$1,164 per year for a family of four, in California it is \$3,768. Does your new policy not mean that the family planning program in these States will be determined by these respective welfare levels?

Dr. SIMMONS. It will have an effect. The State will determine, as you know, under medicaid what level of eligibility they feel is appropriate for their population.

Senator CRANSTON. So there is a severe limit in some States in terms of what can be provided?

Dr. SIMMONS. Again I would not agree with the words, "severe limit." In some States, as you know, the dollar value goes a lot further than in others. I would have to study individual instances in order to determine whether there is a severe limit.

Dr. HELLMAN. There is one other item that comes into effect. It is possible to shift project grant funds to serve some individuals who are not eligible through title IV-A or XIX. It is also possible that the eligibility rules will be changed in the future both by the Congress and by the State.

Senator CRANSTON. Is the success of the plan in all States or each State then dependent upon action in the State legislature?

Dr. SIMMONS. To a large extent medicaid eligibility determination is delegated to States. Yes, that varies.

Senator CRANSTON. Then we become rather dependent in terms of a national program on what happens locally in each State where there are special financing problems in comparison to the general national norm.

Dr. SIMMONS. I suppose we would turn that around and say we thus gain the ability of those closest to the program to determine which needs are most important in that State and what method is most appropriate to fill those needs, so you have a two-sided coin.

Senator CRANSTON. If we had relied upon that strategy originally, we would not have passed the original law. We would be serving probably 2 million less than we are now serving, so I have great doubts about where that takes us.

Dr. SIMMONS. We agree that certain actions were necessary to establish the program. However, given where we are in 1973, another approach now seems appropriate.

Senator CRANSTON. Would you feel perhaps we should extend title X until we know what the situation will be from State to State?

Dr. SIMMONS. No, Mr. Chairman, we do not.

Senator CRANSTON. If it was a good program, and an effective program, which did a good job, why do we abandon it?

Dr. SIMMONS. First of all, we are not abandoning it. The project grants will continue. What we are doing is improving it by beefing up two mechanisms.

Senator CRANSTON. From 1969 to 1971 the administration's No. 1 priority was to reform the present welfare system. Now you want to take a successful program like family planning and lock it into the inequitable welfare system, which has not yet been reformed, and for which reform seems to be abandoned. I just wonder how that can be justified.

Dr. SIMMONS. Mr. Chairman, we do not see that we are locking into an inequitable system. We sincerely believe that the program we are proposing will make family planning services available on a more equitable basis. Through the medicaid system, such services will be available throughout the country to every individual who is eligible under the rules of his State.

Senator CRANSTON. Every citizen is not eligible for medicaid.

Dr. SIMMONS. I said under the appropriate criteria of the State in which he resides.

Senator CRANSTON. Yes, but qualifications are very restrictive among the various States.

Dr. SIMMONS. In some areas they are.

Senator CRANSTON. I note that the revised fiscal year 1973 budget, and the proposed 1974 budget anticipate roughly a \$18 million increase each year over the \$7.5 million level of family planning expenditures which the Department estimated for fiscal year 1972. The budget contains much smaller increases under title IV-A, and I take it therefore that you anticipate most of the growth to come under medicaid, not under title IV-A.

Dr. SIMMONS. Yes; that is correct.

Senator CRANSTON. Have you made a State-by-State study of the rules for eligibility for services that will be rendered so that you know what will happen in each State as you plan your approach under medicaid?

Dr. SIMMONS. This is in process now, Mr. Chairman.

Senator CRANSTON. When will that State-by-State survey be completed?

Dr. SIMMONS. I cannot give you a definite time on that, Mr. Chairman. We will make it available as soon as it is available to us.

Senator CRANSTON. Would you let us know, and then submit it for the record.

Dr. SIMMONS. Yes.

[The information subsequently supplied follows:]

State-by-State Survey of Eligibility for Medicaid

Title XIX eligibility for categorically related individuals is determined by income level. Each State is responsible for establishing its own standard of need.

In addition to covering persons receiving cash assistance, 27 States cover the medically needy (persons who, except for income and resources, would be categorically eligible).

California	Massachusetts	Pennsylvania
Connecticut	Michigan	Puerto Rico
District of Columbia	Minnesota	Rhode Island
Guam	Nebraska	Utah
Hawaii	New Hampshire	Vermont
Illinois	New York	Virginia
Kansas	North Carolina	Virgin Island
Kentucky	North Dakota	Washington
Maryland	Oklahoma	Wisconsin

Title XIX family planning services are available to minors who can be considered sexually active. Seventeen States include all financially eligible children under 21 without regard to family characteristics of death, absence, disability, or unemployment and without regard to institutionalization or foster care placement.

Connecticut	Pennsylvania	Washington
Massachusetts	Virgin Island	Kansas
Oklahoma	Hawaii	New York
Vermont	Minnesota	Utah
District of Columbia	Puerto Rico	Maryland
Michigan	Wisconsin	

Twenty-seven States have elected to include families with an unemployed father in their Medicaid programs.

California	Maine	Oklahoma
Colorado	Maryland	Oregon
Delaware	Massachusetts	Pennsylvania
District of Columbia	Michigan	Puerto Rico
Guam	Minnesota	Rhode Island
Hawaii	Missouri	Utah
Illinois	Nebraska	Vermont
Kansas	New York	Washington
Kentucky	Ohio	West Virginia

Tables Showing Need and Payment Standards in Effect as of July 1972

Table 3.—Aid to the blind: Monthly amount for basic needs under full standard and payment standard and largest amount paid for basic needs for a blind person, by State, July 1972

State	Monthly amount for basic needs				Largest amount paid for basic needs	
	Full standard	Payment standard 1/			Amount	Percent of full standard for basic needs in column (1)
		Total	Other than rent	Rent		
	(1)	(2)	(3)	(4)	(5)	(6)
Alabama.....	\$125	\$125	\$85	\$40	\$125	100
Alaska.....	250	250	(2/)	(2/)	250	100
Arizona.....	150	150	81	69	150	100
Arkansas.....	109	109	76	33	105	96
California.....	190	190	135	2/ 63	190	100
Colorado.....	109	109	58	2/ 51	109	100
Connecticut.....	181	181	78	103	181	100
Delaware.....	109	109	113	76	109	100
District of Columbia.....	204	153	85	2/ 68	153	75
Florida.....	114	114	64	50	114	100
Georgia.....	111	111	71	40	91	82
Hawaii.....	(2/)	(2/)	(2/)	(2/)	(2/)	(2/)
Idaho.....	154	154	75	2/ 59	154	100
Illinois.....	182	182	106	76	182	100
Indiana.....	169	169	72	97	169	100
Iowa.....	185	185	85	100	125	68
Kans.	144	144	114	30	144	89
Kansas.....	203	203	78	125	203	100
Kentucky.....	94	94	73	23	94	100
Louisiana.....	106	106	71	35	101	95
Maine.....	123	123	80	43	115	93
Maryland.....	130	94	55	41	94	74
Massachusetts.....	2/ 180	2/ 180	(2/)	(2/)	2/ 180	100
Michigan.....	224	224	79	165	224	100
Minnesota.....	183	183	78	105	183	100
Mississippi.....	150	150	100	50	75	50
Missouri.....	250	250	210	2/ 40	100	40
Montana.....	120	111	82	29	111	92
Nebraska.....	182	182	82	100	182	100
Nevada.....	153	153	81	74	153	100
New Hampshire.....	173	173	105	70	173	100
New Jersey.....	2/ 162	2/ 162	(2/)	(2/)	2/ 162	100
New Mexico.....	116	116	79	37	116	100
New York.....	159	159	84	2/ 75	159	100
North Carolina.....	120	120	68	2/ 72	120	100
North Dakota.....	2/ 123	2/ 123	(2/)	(2/)	2/ 123	100
Ohio.....	126	126	68	2/ 58	126	100
Oklahoma.....	130	130	100	30	130	100
Oregon.....	153	153	100	53	153	100
Pennsylvania.....	190	190	132	58	115	61
Puerto Rico.....	54	54	34	2/ 20	22	40
Rhode Island.....	170	170	90	2/ 80	170	100
South Carolina.....	103	103	68	35	95	92
South Dakota.....	180	180	80	100	180	100
Tennessee.....	102	102	69	33	97	95
Texas.....	110	110	79	31	110	100
Utah.....	122	122	89	33	122	100
Vermont.....	196	196	92	104	196	100
Virgin Islands.....	52	52	40	12	52	100
Virginia.....	153	153	58	2/ 95	153	100
Washington.....	151	151	90	61	151	100
West Virginia.....	(2/)	(2/)	(2/)	(2/)	(2/)	(2/)
Wisconsin.....	205	201	71	130	201	98
Wyoming.....	139	139	74	2/ 65	106	75

1/ Payment standard for a blind person living in rented quarters for which monthly rental, unless otherwise indicated, is at least as large as the maximum amount allowed by the State for this item.

2/ Data not reported.

3/ Utilities included in rent.

4/ Estimated average.

5/ Flat allowance; for New Jersey and North Dakota, includes special needs.

6/ Rent included in rent. Higher rent authorized with supervisory approval.

Note: The full standard is the amount necessary for basic needs as defined in the State's plan.

The payment standard is the amount from which income "available for basic needs" is subtracted to determine the amount of assistance to which a blind person is entitled. This is also the amount used to determine whether or not financial eligibility exists.

The largest amount paid is the total monthly payment for basic needs made under State law or agency regulations to a blind person with no other income.

Table 4.—Aid to the permanently and totally disabled: Monthly amount for basic needs under full standard and payment standard and largest amount paid for basic needs for a disabled person, by State, July 1972

State	Monthly amount for basic needs				Largest amount paid for basic needs	
	Full standard	Payment standard 1/			Amount	Percent of full standard for basic needs in column (1)
		Total	Other than rent	Rent		
	(1)	(2)	(3)	(4)	(5)	(6)
Alabama.....	\$122	\$110	\$74	\$36	990	74
Alaska.....	230	230	(Q/)	(Q/)	230	100
Arizona.....	130	130	81	49	130	100
Arkansas.....	109	109	74	35	109	96
California.....	177	177	114	2/ 63	177	100
Colorado.....	123	123	50	65	123	100
Connecticut.....	181	181	78	103	181	100
Delaware.....	117	117	74	43	117	100
District of Columbia...	204	153	85	2/ 68	153	75
Florida.....	114	114	64	50	114	100
Georgia.....	111	111	71	40	91	82
Guam.....	(Q/)	(Q/)	(Q/)	(Q/)	(Q/)	(Q/)
Hawaii.....	134	134	75	5/ 59	134	100
Idaho.....	182	182	106	76	182	100
Illinois.....	169	169	72	97	169	100
Indiana.....	185	185	85	100	80	43
Iowa.....	122	117	84	33	117	96
Kansas.....	203	203	78	125	203	100
Kentucky.....	96	96	73	23	96	100
Louisiana.....	64	64	43	5/ 19	64	100
Maine.....	123	123	80	43	115	93
Maryland.....	130	96	55	41	96	74
Massachusetts.....	178	178	131	47	178	100
Michigan.....	234	234	79	145	234	100
Minnesota.....	183	183	78	105	183	100
Mississippi.....	130	130	100	30	75	50
Missouri.....	170	170	130	5/ 40	80	47
Montana.....	120	111	82	29	111	92
Nebraska.....	182	182	82	100	182	100
New Hampshire.....	173	173	103	70	173	100
New Jersey.....	2/ 162	2/ 162	(Q/)	(Q/)	2/ 162	100
New Mexico.....	116	116	79	37	116	100
New York.....	159	159	84	5/ 75	159	100
North Carolina.....	112	112	40	5/ 72	112	100
North Dakota.....	2/ 125	2/ 125	(Q/)	(Q/)	2/ 125	100
Ohio.....	126	116	50	2/ 50	116	92
Oklahoma.....	130	130	100	30	130	100
Oregon.....	153	122	80	42	122	80
Pennsylvania.....	146	146	81	65	146	100
Puerto Rico.....	34	34	34	5/ 20	22	40
Rhode Island.....	170	170	90	5/ 80	170	100
South Carolina.....	87	87	52	35	80	92
South Dakota.....	100	100	80	100	100	100
Tennessee.....	102	102	69	33	97	95
Texas.....	116	110	79	31	105	91
Utah.....	153	112	76	36	112	73
Vermont.....	196	196	92	104	196	100
Virgin Islands.....	52	52	40	12	52	100
Virginia.....	152	152	57	2/ 95	152	100
Washington.....	151	151	90	61	151	100
West Virginia.....	(Q/)	(Q/)	(Q/)	(Q/)	(Q/)	(Q/)
Wisconsin.....	205	201	71	130	201	90
Wyoming.....	127	127	62	2/ 45	104	82

1/ Payment standard for a disabled person living in rented quarters for which monthly rental, unless otherwise indicated, is at least as large as the maximum amount allowed by the State for this item.

2/ Data not reported.

3/ Utilities included in rent.

4/ Enclosed average.

5/ Plus allowance; includes special needs.

6/ Rent included in rent. Higher rent authorized with supervisory approval.

Note: The full standard is the amount necessary for basic needs as defined in the State's plan.

The payment standard is the amount from which income "available for basic needs" is subtracted to determine the amount of assistance to which a disabled person is entitled. This is also the amount used to determine whether or not financial eligibility exists.

The largest amount paid is the total monthly payment for basic needs made under State law or agency regulations to a disabled person with no other income.

Table 3.--Aid to families with dependent children: Monthly amount for basic needs under full standard and payment standard and largest amount paid for basic needs for a family consisting of two recipients, by State, July 1972

State	Monthly amount for basic needs				Largest amount paid for basic needs	
	Full standard	Payment standard 1/			Amount	Percent of full standard for basic needs in column (1)
		Total	Other than rent	Rent		
	(1)	(2)	(3)	(4)	(5)	(6)
Alabama.....	\$148	\$62	\$43	\$19	\$62	42
Alaska.....	300	300	(2/)	(2/)	175	58
Arizona.....	180	180	124	56	117	65
Arkansas.....	149	149	114	35	91	61
California.....	3/ 210	3/ 210	(2/)	(2/)	3/ 190	90
Colorado.....	167	167	102	65	167	100
Connecticut.....	205	205	102	103	205	100
Delaware.....	181	181	122	5/ 59	96	53
District of Columbia.....	206	154	81	3/ 73	154	75
Florida.....	143	143	81	62	93	65
Georgia.....	161	161	121	40	79	49
Hawaii.....	(2/)	(2/)	(2/)	(2/)	(2/)	(2/)
Idaho.....	252	252	108	5/ 144	252	100
Illinois.....	229	206	138	68	206	90
Indiana.....	217	217	120	97	217	100
Iowa.....	247	247	147	100	145	59
Iowa.....	186	186	138	48	151	81
Kansas.....	260	247	122	125	247	95
Kentucky.....	146	146	110	36	107	73
Louisiana.....	110	63	45	5/ 18	63	57
Maine.....	205	205	137	68	86	42
Maryland.....	187	131	90	41	131	70
Massachusetts.....	236	236	158	78	236	100
Michigan.....	261	261	116	145	261	100
Minnesota.....	242	242	127	115	242	100
Mississippi.....	205	205	155	50	30	15
Missouri.....	213	213	173	5/ 40	80	38
Montana.....	143	132	95	37	132	92
Nebraska.....	2/ 217	3/ 217	(2/)	(2/)	2/ 158	73
Nevada.....	228	125	78	47	125	55
New Hampshire.....	221	221	136	85	221	100
New Jersey.....	3/ 214	3/ 214	(2/)	(2/)	3/ 214	100
New Mexico.....	135	135	98	37	119	88
New York.....	219	219	134	5/ 85	204	94
North Carolina.....	147	126	64	2/ 62	126	86
North Dakota.....	3/ 190	3/ 190	(2/)	(2/)	3/ 190	100
Ohio.....	173	140	60	3/ 80	140	81
Oklahoma.....	163	122	92	30	122	85
Oregon.....	206	165	118	47	165	80
Pennsylvania.....	218	218	139	79	218	100
Puerto Rico.....	78	78	58	5/ 20	31	40
Rhode Island.....	202	202	122	3/ 80	202	100
South Carolina.....	133	133	89	44	66	50
South Dakota.....	220	209	114	95	209	95
Tennessee.....	142	142	109	33	99	70
Texas.....	136	102	77	25	102	75
Utah.....	205	150	102	48	150	73
Vermont.....	245	245	161	104	245	100
Virgin Islands.....	92	92	80	12	92	100
Virginia.....	196	186	91	3/ 95	186	95
Washington.....	216	214	128	86	214	99
West Virginia.....	(2/)	(2/)	(2/)	(2/)	(2/)	(2/)
Wisconsin.....	251	245	115	130	245	98
Wyoming.....	168	155	84	3/ 71	155	92

1/ Payment standard for the specified type of family living by itself in rented quarters for which monthly rental, unless otherwise indicated, is at least as large as the maximum amount allowed by the State for this item.

2/ Data not reported.

3/ Flat allowance; includes special needs.

4/ Estimated average.

5/ Utilities included in rent.

6/ Rent included in rent. Higher rent authorized with supervisory approval.

Note: The full standard is the amount with which income from all sources is compared to determine whether or not financial eligibility exists. Use of the full standard for this purpose (where this is different from the payment standard) is mandatory only for AFDC applicant families with earned income who have not received assistance in any one of the four preceding months.

The payment standard is the amount from which income "available for basic needs" is subtracted to determine the amount of assistance to which a family is entitled.

The largest amount paid is the total monthly payment for basic needs made under State law or agency regulations to families with no other income.

Table 6.—Aid to families with dependent children: Monthly amount for basic needs under full standard and payment standard and largest amount paid for basic needs for a family consisting of four residents, by State, July 1972

State	Monthly amount for basic needs				Largest amount paid for basic needs	
	Full standard	Payment standard 1/			Amount	Percent of full standard for basic needs in column (1)
		Total	Other than rent	Rent		
	(1)	(2)	(3)	(4)	(5)	(6)
Alabama.....	\$230	\$97	\$78	\$19	\$97	42
Alaska.....	400	400	(Q/)	(Q/)	375	94
Arizona.....	282	282	201	81	184	65
Arkansas.....	229	229	194	35	111	48
California.....	3/ 314	3/ 314	(Q/)	(Q/)	3/ 280	89
Colorado.....	242	242	175	69	242	100
Connecticut.....	334	334	174	162	338	100
Delaware.....	287	287	224	4/ 43	152	53
District of Columbia...	314	239	145	3/ 94	239	75
Florida.....	223	223	142	81	144	65
Georgia.....	227	227	181	46	149	66
Hawaii.....	(Q/)	(Q/)	(Q/)	(Q/)	(Q/)	(Q/)
Idaho.....	334	334	177	3/ 157	334	100
Illinois.....	272	282	214	68	282	100
Indiana.....	272	272	175	97	272	100
Iowa.....	363	363	263	100	205	56
Kansas.....	300	300	230	70	243	81
Kentucky.....	343	322	197	125	322	94
Kentucky.....	234	234	182	52	171	73
Louisiana.....	193	108	84	3/ 22	108	56
Maine.....	349	349	234	115	148	48
Maryland.....	311	200	159	41	200	64
Massachusetts.....	349	349	271	78	349	100
Michigan.....	341	341	216	145	341	100
Minnesota.....	339	339	209	130	339	100
Mississippi.....	277	277	227	50	60	22
Missouri.....	303	303	263	3/ 40	130	43
Montana.....	225	204	148	58	204	92
Nebraska.....	3/ 307	3/ 307	(Q/)	(Q/)	3/ 224	74
Nevada.....	320	176	118	58	176	55
New Hampshire.....	294	294	209	85	294	100
New Jersey.....	3/ 324	3/ 324	(Q/)	(Q/)	3/ 324	100
New Mexico.....	203	203	154	47	179	88
New York.....	334	334	231	3/ 8/105	313	93
North Carolina.....	184	159	97	3/ 62	159	86
North Dakota.....	3/ 300	3/ 300	(Q/)	(Q/)	3/ 300	100
Ohio.....	254	200	104	3/ 96	200	78
Oklahoma.....	222	149	40	180	180	85
Oregon.....	333	267	213	54	267	80
Pennsylvania.....	313	313	227	86	313	100
Puerto Rico.....	132	132	112	4/ 20	33	40
Rhode Island.....	243	243	183	3/ 80	243	100
South Carolina.....	200	208	164	44	104	50
South Dakota.....	300	285	190	95	285	95
Tennessee.....	217	217	184	33	132	61
Texas.....	197	148	115	33	148	75
Utah.....	322	235	160	75	235	73
Vermont.....	335	335	231	104	335	100
Virgin Islands.....	164	164	150	16	164	100
Virginia.....	279	241	164	3/ 95	241	94
Washington.....	308	294	203	91	294	94
West Virginia.....	(Q/)	(Q/)	(Q/)	(Q/)	(Q/)	(Q/)
Wisconsin.....	312	302	172	150	302	97
Wyoming.....	283	260	160	3/ 100	227	80

1/ Payment standard for the specified type of family living by itself in rented quarters for which monthly rental, unless otherwise indicated, is at least as large as the maximum amount allowed by the State for this item.

3/ State not reported.

3/ Flat allowance; includes special needs.

3/ Estimated average.

3/ Utilities included in rent.

3/ Rent included in rent. Higher rent authorized with supervisory approval.

Note: The full standard is the amount with which income from all sources is compared to determine whether or not financial eligibility exists. Use of the full standard for this purpose (where this is different from the payment standard) is mandatory only for AFDC applicant families with earned income who have not received assistance in any one of the four preceding months. The payment standard is the amount from which income "available for basic needs" is subtracted to determine the amount of assistance to which a family is entitled. The largest amount paid is the total monthly payment for basic needs made under State law or agency regulations to families with no other income.

Senator CRANSTON. So you have in effect developed a strategy now, but you do not have those statistics, those rules, those regulations, those laws.

What astounds me about where we now find ourself is that you have launched a master plan for the Nation without knowing what the rules, regulations, laws, eligibility, and services available will be from State to State where the plan is supposed to be implemented.

Dr. SIMMONS. Mr. Chairman, I just want to be sure it is understood. We had a master plan which we launched in 1969. That plan by 1973 has resulted in a very successful, viable program.

We believe that we will continue to have a successful program. It is the intent of Congress in the Social Security Amendments of 1972 to provide equal access to services through medicaid, to those eligible. We do not see this as a major change. The project grants will continue in areas where there may be a particular need. Such grants will serve as a cushion until the national health insurance mechanism is in operation.

If this approach is not successful, Congress can change the medicaid program, and each State can shape the program to its special needs.

Senator CRANSTON. Of course, there was never an indication by Congress there was not a need for further project grants under title X.

At any rate I will be interested in seeing what your State-by-State survey shows because then we will know more about how this is going to work State by State.

Under medicaid there are 25 States where essentially the only individuals who are eligible for medicaid are those who are already on welfare. The provision of family planning services to these women is certainly desirable but, by putting primary emphasis on medicaid in these States, are you not excluding the working poor whom we also want to help?

Dr. SIMMONS. First, Mr. Chairman, that survey was made before the enactment of amendments to the law relative to family planning services which (1) make these services mandatory; (2) provide a 90-percent matching; and (3) provide a penalty for noncompliance. So I really do not think that is indicative of what will in fact prevail in the future.

Second, I think it is important to point out that project grants are still an extremely substantial part of this program.

Senator CRANSTON. Of course, you stated earlier the regulations have not yet been issued.

Dr. SIMMONS. They are in process.

Senator CRANSTON. But we do not know yet what they will be or how the States will respond, so the situation has not changed.

Dr. SIMMONS. That is correct, Mr. Chairman. It is in process.

Senator CRANSTON. In the States which do cover the medically indigent under medicaid—how many States is that, by the way?

Dr. SIMMONS. We will provide that for the record. I do not have that figure, Mr. Chairman.

[The information subsequently supplied follows:]

States Which Cover the Medically Indigent

Twenty-seven States cover people in public assistance categories (people qualifying as aged, blind, disabled, or members of families with dependent children*) who are financially eligible for medical, but not for financial assistance. These States are:

California	New York
Connecticut	North Carolina
District of Columbia	North Dakota
Guam	Oklahoma
Hawaii	Pennsylvania
Illinois	Puerto Rico
Kansas	Rhode Island
Kentucky	Utah
Maryland	Vermont
Massachusetts	Virgin Islands
Michigan	Virginia
Minnesota	Washington
Nebraska	Wisconsin
New Hampshire	

*Usually families with at least one parent absent or incapacitated.

Senator CRANSTON. In the States which do cover the medically indigent under medicaid the statutory income ceiling is set at 133 $\frac{1}{3}$ percent of the welfare level. This is below the income ceiling established in the new title IVA regulations and 100 percent below the level set for daycare in that program.

What is your rationale for focusing all growth in family planning on the one program which has the lowest eligibility in terms of income?

Dr. SHULTZ. The eligibility requirements which you have stated are in the actual legislation and therefore do bind the department. The reason for moving in the direction of use of these programs as a mode of expansion is in accord with the overall policy approach of moving in the direction of equitable access within each State to services.

We also have the requirement under Social Security Act, title V that family planning services be made available statewide by 1975. This is one of the forces that has led to expansion of coverage by the States.

This is reported in the current 5-year plan progress report and will be reported to the Congress again in the next report. So we see that we have a number of items which express congressional intent that there be broad, equitable access to services. The administration is moving in the direction of reinforcing this through its revised policies.

Senator CRANSTON. The eligibility requirements are going to be left up to the States then rather than by a national decision?

Dr. SHULTZ. Except as specifically provided in Federal legislation and regulation.

Dr. HELLMAN. And by the program guidelines. For example, the single woman of childbearing age, otherwise eligible, who does not have children or does not fit into one of the categorically eligible groups, is not covered in the regulations. But she is to be included in the forthcoming program regulation guidelines for the 1972 social service amendments.

Senator CRANSTON. Regarding a State by State medicaid eligibility and services study, would it be possible for me to submit to you in just a few days certain items we feel it would be useful to cover in this study for each State and jurisdiction?

Dr. SIMMONS. Certainly, Mr. Chairman.

Senator CRANSTON. I presume you are aware that witnesses appearing before the hearings have raised serious concerns that focusing these services on only welfare-related clients gives the appearance of in some cases genocidal motivation for Federal family planning efforts.

Dr. SIMMONS. We are aware of it. We do not agree it is in any way intended.

Senator CRANSTON. Would you please comment on that and on my remarks in that connection in my opening statement today. How do you deal with that concern?

Dr. SIMMONS. I do not understand the reason for the concern, Mr. Chairman. It is clear to me that is not the administration's intent. The President has said that the Federal Government has the obligation to provide services for those who want them and cannot afford them.

We put into place a system that is succeeding, very dramatically, in doing that. It has nothing to do with genocide, not anything against

the blacks, the browns, or any other disadvantaged group. As you know, about 60 percent of the population served is white. So it is certainly not related to the color suggestion which has been made. We just do not agree with those suggestions.

Dr. HELLMAN. Senator, you ask how we deal with the problem. Ever since the President's message in 1969 directed this program to people who could not afford it, we have had the charge of genocide.

Our responses to this charge are as follows: First, the program is a preventive health program which has clearly demonstrated its health benefits to women and children. Second, the program is voluntary.

Senator CRANSTON. Do the medicaid and title IV (a) laws and regulations provide the protection for volunteerism that we find elsewhere?

Dr. SCHULTZ. Yes. IV (a) and XIX emphasize voluntary in the legislation.

Senator CRANSTON. Presently section 1007 of title X reads as follows:

[The information referred to follows:]

"VOLUNTARY PARTICIPATION

"SEC. 1007. The acceptance by any individual of family planning services or family planning or population growth information (including educational materials) provided through financial assistance under this title (whether by grant or contract) shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such service or information.

Dr. SHULTZ. Yes; we specifically do. Section 402 (a) provides that family planning services are offered them and are provided promptly to all individuals voluntarily requesting such services.

We will furnish the exact citations for the record, because it applies to both IV (a) and XIX, and we will see that they are provided to the committee, but each does contain that specific citation for voluntary access.

Senator CRANSTON. I think the problem that has led to this concern about punitive or genocidal motives is tying the program into welfare programs which obviously are primarily aimed at people in the lowest income brackets who tend to be the people in certain minority communities who have a very hard time getting employment.

As you know, we have had great concern here over inquiries into income and ability to pay in relationship to the availability of services.

In the family planning legislation, this committee has placed considerable stress on the necessity of provision of family planning services to all sexually active persons who have not yet had children. Again we are stressing the preventive aspects of the program.

How can the Department expect to meet this expectation through medicaid where the very eligibility for the program is predicated upon the presence of a child in the family unit?

Dr. HELLMAN. I mentioned it before. Perhaps you did not hear, but the guidelines are going to make it possible for women otherwise eligible, but who are single, to receive these services.

Senator CRANSTON. The new medicaid guidelines? Is this what you are talking about?

Dr. HELLMAN. These are the title IV (a) guidelines.

Senator CRANSTON. Are there not restrictive eligibility requirements that you come up against under title IV (a) ?

Dr. HELLMAN. Yes; I think there are restrictive eligibility requirements, but as we have emphasized before, the continuation of the project grants gives us a cushion to make up for these restrictive requirements, and there is no reason to believe that the Congress will not look at these restrictions very carefully in the next year or so. They are not immutable.

Senator CRANSTON. Is it true that only about one-fifth of the women who want and need but do not now get family planning services would be eligible for either medicaid or title IV (a) ?

Dr. HELLMAN. That is the current figure reported by the National Family Planning Reporting System for those receiving services.

Senator CRANSTON. Do you have any estimate of the future situation?

Dr. SHULTZ. Senator, that is why we are conducting this current study, to assess what will be the probable effect of the new amendments. We hopefully will be able to be responsive when we have the results of this study available.

Senator CRANSTON. Then again you have made your plans and set your course without the data.

Dr. SHULTZ. Sir, it was apparent that the incentives that were built into the legislation passed by the Congress in late 1972 were such that we had reason to believe that the course upon which we set was responsive to the problem.

Senator CRANSTON. How will the services be extended to the other 80 percent ? Through project grants ?

Dr. SIMMONS. Yes. As you know, there are still \$113 million in project grants which is over 60 percent of the total funding.

Senator CRANSTON. That would serve the 2 million now served. What about the 2.3 million not now served ?

Dr. HELLMAN. The 2.3 million not now served were part of a planning estimate used in the previous 5-year plan. That was a planning estimate. Now, the estimates of need are not to be made nationally, but by the individual States. The total of what the States estimate remain to be served may not be 2.3 million.

Senator CRANSTON. Is that estimate of need an OMB estimate ?

Dr. SIMMONS. No, it is not, Mr. Chairman. It is the Department's estimate.

Mr. Chairman, I guess we keep going back to the fact that it is clearly the intent of Congress under the Social Security Act of 1972 to embark upon this kind of approach, and that is to finance these services on a needs basis primarily through medicaid. Congress I believe has spoken very clearly on that, and we are carrying out that intent in this program.

Senator CRANSTON. What about the intact family, where the wife and husband are present? You cannot use medicaid for them, even if they do have children. Are you advocating no family planning for these couples?

Dr. SIMMONS. No, Mr. Chairman. Some of these questions are complicated. We would be glad to answer in full for the record whatever questions you may have on the eligibility.

Senator CRANSTON. The problem is if you have difficulty determining at once what the situation is, how are the people in the field going to know under new rules and regulations who will be eligible, when individuals apply at their offices?

Dr. SIMMONS. The regional offices do provide that assistance to the individual programs.

Senator CRANSTON. Suppose there is a young woman who has already had one child out of wedlock. We have given her some job training, and she now works as a clerk for \$75 a week. She is not eligible for medicaid in her State. She is eligible for daycare services under the new title IV (a) regulations, but not for family planning services.

What is going to happen to her when she gets pregnant?

Dr. SIMMONS. Again, I would have to provide most of those specific answers for the record.

Senator CRANSTON. I have some others to submit like that.

[The information subsequently supplied follows:]

MEDICAID AND TITLE IV(A) ELIGIBILITY

1. Let me take a few examples of life situations and see how these people would be affected under current eligibility requirements for Medicaid and Title IV(A).
 - A. --There is a young woman, for example, who has already had one child out of wedlock. She has been given some job training and she now works as a clerk for \$75 a week. She is not eligible for Medicaid in her state. She is eligible for day care services under the new Title IV(A) regulations but not for family planning services. Now what's going to happen to her when she gets pregnant?
 - B. --Take another instance--a family of four. The husband is employed as a dishwasher and makes \$90 a week. They are not eligible for Medicaid. If the wife becomes pregnant in an unplanned way, don't you think there is a good likelihood that the father will decide that the family might be better off on AFDC and leave?
 - C. --What would happen to the high school senior if she becomes pregnant. Unless she happens to be part of a welfare family --and statistically she is less likely to be rather than more likely--she would not be eligible for Medicaid even though her family income may be quite low. More likely than not, she will not finish school. She may either start a very marginal job or she may be forced to go on welfare herself for several years to support her baby. She definitely will be handicapped by her lack of formal education and by this accidental pregnancy for the rest of her life.

Public Health Service Act project grants and Social Security Act Title V formula grants to States will still be available to provide family planning services to many of those not eligible for either Title IV(A) or Title XIX assistance.

2. We are not clear about the new guidelines under Title IV(A) regarding unmarried women which Dr. Hellman referred to on May 23. Could you please submit these for the record and specify the authorities to which they will be applicable?

The proposed regulations for Title IV(A) are currently being revised. The guidelines will not be available until the final regulations are approved.

Senator CRANSTON. In regard to various examples like that, it is our intent that high priority be given to avoiding this kind of tragedy, and since all these people are excluded from coverage under the title IV(a) and XIX programs, it is imperative that there be project grant funds to take care of them and the others in the 80 percent of the potential patient population, which will not qualify for these narrowly defined programs.

I am glad that you have given your assurance on that point.

Dr. SHULTZ. Title V of the Social Security Act in part especially provides for just such cases as you are citing, in the maternal and child health benefits. Because there is no specific eligibility requirement stated for those programs, there is a built-in device, which is actually the oldest existing legislative provision under which we operate, that does provide for these cases.

Senator CRANSTON. I would like to quote from section 221.6 of the new title IV(a) regulations which requires that the potential welfare recipient must "have a specific problem or problems which are susceptible to correction or amelioration through provisions of a service and which will lead to dependence on federal assistance under title IV(a) within 6 months if not corrected or ameliorated.

If pregnancy is the specific problem, which might be remedied by family planning services, and if a normal pregnancy takes 9 months, how is a potential recipient going to qualify for family planning services under this regulation?

Dr. SIMMONS. Such individuals can be served by programs not requiring title IV-A eligibility.

Senator CRANSTON. Dr. Hellman, I would like you to look at the certification and recertification procedures set up under the new regulations for title IV(a) for potential recipients. Requiring these procedures for family planning services which should be provided immediately upon request on a walk-in basis makes no sense to me and deters utilization.

We understand the need for accountability but even if it worked, would not this procedure probably cost more administratively than the cost of providing the family planning service itself?

Dr. HELLMAN. I would have to answer that one for the record, Senator.

[The information subsequently supplied follows:]

Administrative Costs of Certification Under Title IV-A

Congress has mandated that services provided under Title IV-A be provided to persons who meet eligibility requirements. Hence, certification is required in order to assure that the persons served are eligible. Recertification is required to establish continued eligibility.

Costs to certify and recertify individuals for specific services such as family planning are not available. Since individuals are usually certified for more than one type of service, the costs of certification do not relate to family planning services alone.

Senator CRANSTON. Are infertility services eligible for 90 percent matching provisions of family planning services under title XIX?

Dr. SHULTZ. Yes, they would be, Senator.

Senator CRANSTON. Do you have an estimate of the range of reimbursement rates which States apply under title XIX for family planning services?

Dr. SIMMONS. We are not sure we understand your question.

Senator CRANSTON. What is the range of reimbursement rates which States apply under title XIX for family planning services?

Dr. SHULTZ. This part of the study that we are carrying out now. The rates of reimbursement are subject to negotiation. Some of the reports we have indicate that in some instances it is quite generous and in others it is not so generous. We will have to provide the complete report for the record following receipt of the study which we have alluded to earlier.

Senator CRANSTON. How do you determine how many individuals actually do or will receive family planning services under medicaid?

Is it an estimate, or is it based on a sampling?

Dr. SHULTZ. We may be dealing with two different situations. The figures that have been provided with regard to capacity are estimates. The reported figures of those actually who have been eligible are based on material coming from the National Family Planning Service Reporting System, and some of the other automated data processing systems, plus other studies.

So that we have a combination of information available here.

Senator CRANSTON. Regarding the 5-year plan, since the 5-year plan update which was required by law to be forwarded to the Congress by January 1 has just now reached us, we have been unable to study it adequately. But in your judgment is the administration still committed to the achievement of the objectives set forth in the 5-year plan first submitted in October 1971?

Dr. SIMMONS. We are still committed to provide family planning services to those who desire but cannot afford them.

Senator CRANSTON. Does that mean that you plan to serve 6.6 million by 1976?

Dr. SIMMONS. No. It means that we are prepared to subsidize these services for those who desire but cannot afford them.

The number is indeterminate at this time, and it was indeterminate at the time that planning estimate was made. We recognize it as such. That figure can change from 3.5 million to 6 million depending on your definition of what is a person in need.

Senator CRANSTON. Are we going to have a reduced definition that is going to change the goal?

Dr. SIMMONS. No, I would not call it a reduced definition. There is a definition, some of which is spelled out in law, and some of which we can adopt as appropriate for planning purposes.

Dr. HELLMAN. I think the definition you will get—I cannot give you the number—will be the aggregate of the States' estimates of individual State needs.

Senator CRANSTON. In view of employment problems, inflation problems, and other problems, it is not very likely that somebody who could not afford services 2 years ago could afford them now.

Dr. SIMMONS. I believe it is. I believe that the employment situation has changed at least regionally. Certainly other situations have changed, one of which being how many children a particular individual wants. That is certainly in a state of flux.

Senator CRANSTON. Could you submit that for the record, taking into account inflation?

Dr. HELLMAN. We are waiting for data from the Bureau of the Census which will give us numbers of people in various income categories. We had intended to have those data for this 5-year plan progress report. The data are not yet ready, and I cannot tell when they will be ready.

Senator CRANSTON. Are you saying that the statistics in the original 5-year plan, that were in the projections, were arrived at on the basis of inadequate data?

Dr. HELLMAN. No, sir. They were perfectly adequate data for planning, and they are based on certain assumptions. They were planning data. They were not a commitment as far as the administration was concerned to a specific number of patients.

Senator CRANSTON. The chart on page 58 (table 25) does not contain estimates of the required level of Federal funding for the next 3 years on which we can base our legislative proposals. Could you provide those figures, identified by program and statutory authority, and tell us how these estimates are different from those Secretary Richardson forwarded to this committee in November 1971?

That would be for the record.

Dr. HELLMAN. We do not have available the Federal budget estimates for fiscal years 1975 and 1976.

Senator CRANSTON. In November 1971 it was broken out. Will you provide for the record whatever you can?

Dr. SIMMONS. Yes.

[The information subsequently supplied follows:]

ESTIMATES OF NEW FUNDS FOR FAMILY PLANNING SERVICES AND NUMBERS OF RECIPIENTS,
FY 1972 THROUGH FY 1974

	Estimated Federal Expenditures (In Thousands)		Estimated Number of Recipients (In Thousands)		Estimated Federal Cost Per Recipient	
	FY 1972	FY 1973	FY 1974	FY 1972	FY 1973	FY 1974
SRS						
Title IV-A (AFDC)	\$18,500	\$21,400	\$31,500	925	1,100	1,750
Title XIX (Medicaid)	8,700	22,400	30,600	350	550	700
Total SRS	\$27,200	\$43,800	\$62,100	1,275	1,650	2,450
MCBS						
Formula Grants	\$11,700	\$11,700	\$11,700	867	867	867
MIC Project Grants	4,500	4,500	4,500	120	120	120
Total MCBS	\$16,200	\$16,200	\$16,200	987	987	987
MCPPS						
Project Grants	\$88,200	\$98,500 ^{5/}	\$113,500 ^{5/}	1,500	1,700 ^{5/}	1,900 ^{5/}
				59	58	60

1/ No totals are provided since many recipients of Title IV-A family planning social services also receive family planning medical services under Title XIX.

2/ The decrease in estimated Federal cost per recipient from FY 1972 through FY 1974 is a result of the projected decrease in proportion of expenditures for medical services under Title IV-A from 25% in FY 1972 to 15% in FY 1973 and to 10% in FY 1974. Title IV-A is basically a social services program; however, some medical services are purchased.

3/ The increasing Federal cost per recipient from FY 1972 through FY 1974 is due to increasing the Federal match to 90% from a variable match which ranged from 50 to 83%.

4/ The relatively low Federal cost per recipient in the MCBS formula grants program is a result of the fact that States report recipients in programs in which Federal formula grant funds are only a small proportion of total costs.

5/ The increase in funds and recipients for FY 1973 and FY 1974 does not reflect a real increase in program levels since it represents a transfer of funds previously administered by OEO.

Senator CRANSTON. I think you are aware that Public Law 91-572 requires that you furnish data on the projected costs of the program, and obviously we need to know what the Federal share might be since it is the only portion over which we have any control. We have taken some steps in S. 1708 which we hope will insure that we get this information in the future.

I would like to insert in the record Secretary Richardson's November 1971 letter to this subcommittee and the funding projections which accompanied it. This letter anticipated some changes in the mode of funding of family planning services which have not yet come to pass.

He said:

We believe that these costs need to reflect the impact of pending legislation that will drastically alter the way we provide and pay for family planning services. These legislative proposals include: H.R. 1; The Family Health Insurance Plan; the National Health Insurance Standards Act; and anticipated changes in title V of the Social Security Act.

It is clear, however, from the table summarizing the major sources of Federal funding for family planning services that several of the resources listed, such as OEO, have been phased out, and that some of the support now coming from title V of the Social Security Act will be terminated on June 30 of this year.

Does that not place greater importance than ever on the availability of project grants under title X?

Dr. SIMMONS. It places a need for project grants to be still available, and that is why they are available and represent about 60 percent of the total.

The OEO funds are not totally cut off. Some of those programs, as you know, are going to be transferred to HEW.

Senator CRANSTON. Is it clear that you can give us the same break-out of material that Secretary Richardson provided at that time?

Dr. SIMMONS. We will try, Mr. Chairman.

Senator CRANSTON. Is there any change that makes it impossible to do now what they were able to do then?

Dr. SIMMONS. I do not know. I will have to check.

Senator CRANSTON. Let the Secretary know about our interest in trying to get those figures.

[The information requested and subsequently supplied appears on a preceding page.]

Senator CRANSTON. Certain language appeared on page 72 of the second draft of the progress report that most organized programs are facing an increased demand for services and are limited in meeting it solely by lack of funds. This language has been deleted in the final report. In the face of this strong evidence that organized programs are capable of helping substantially to meet the 5-year plan objectives of reaching 6.6 million women wanting services but unable to afford them, I would like to know how you justify shifting any expansion of this program to third party reimbursement?

Dr. SIMMONS. Mr. Chairman, we do not have the document you are quoting from right now, so I am not sure.

Senator CRANSTON. Suppose we submit that. I have another question on the same report that I will also submit for the record.

[The information subsequently supplied follows:]

1. The second progress report on the five-year plan indicates on page 72 of the second draft that most organized programs are facing an increased demand for services and are limited in meeting it solely by lack of funds. This language has been deleted in the final report. In the face of this strong evidence that organized programs are capable of helping substantially to meet the five-year plan objective of reaching 6.5 million women wanting services but unable to afford them, how can you justify shifting any expansion of the program only to third-party reimbursements?

Answer: The projection in the original five-year plan was an estimate solely for planning purposes and does not represent a Federal commitment to support a specific service capacity within any particular time period. As stated in our current progress report, the number of women estimated to need subsidized family planning services at low-income levels over the 12 months of FY 1973 is not a single number, but a range of from 3.3 million at the poverty level to 6.3 million at 150-percent-of-poverty. The Social Security Amendments of 1972 provide significant new incentives for the provision of family planning services. The Act imposes a penalty of one percent per annum on the Federal share of AFDC funds on States which fail to provide these services in the previous year to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Title IV-A -- AFDC -- to 90 percent from 75 percent and increases the Federal share for family planning services under Title XIX -- Medicaid -- to 90 percent from a variable formula with a range from 50 to 83 percent Federal matching.

2. The same progress report draft on page 77 stated that: "SSA public assistance limits eligibility to families with at least one minor child. This means that programs cannot provide services to women who do not have children, a particularly important target group. To accomplish federal family planning services objectives, financing mechanisms are needed to support subsidized services to childless individuals."

"Since only about 20 percent of the individuals currently receiving services through project grant programs are eligible for SSA assistance, programs have been compelled to rely on project grants, both to establish services and to meet operating costs."

The final report and your prepared testimony seem to depart from this reasoning. Was this due to opinions expressed by O.M.B?

Answer: Since the proposed regulations for Title IV(A) are currently being revised, eligibility standards have not yet been determined.

Public Health Service Act project grants and Social Security Act Title V formula grants to States will still be available to provide services to many individuals not eligible under either Title IV(A) or Title XIX.

Senator CRANSTON. Of the 1.2 million individuals deemed to be low income reached by private physicians, what proportion are now reached under medicaid, and what proportion by title IV supported services?

Dr. SIMMONS. I do not have that figure. We will try to provide it for you.

Senator CRANSTON. Fine.

[The information subsequently supplied follows:]

Private Physician Family Planning Patients
Supported by Medicaid

We do not have a breakdown of the actual family planning services for which the States have sought reimbursement under Title XIX since Medicaid has not required the States to report by diagnoses, but rather by class of provider (in-patient hospital, outpatient hospital, clinic, physician or pharmaceutical).

In justifying claims for 90 percent Federal matching in the future, the States will be required to provide detailed information on the family planning services provided.

Private Physician Services Under Title IV-A

In FY 1972, 925,000 individuals received family planning social and medical services under Title IV-A. Of this total, 100,000 received medical services paid for with Title IV-A funds. One hundred seventy-eight thousand of the total 925,000 received payment for medical services under Title XIX. It is not known how many of the 278,000 individuals who received medical services were served by private physicians.

Senator CRANSTON. The progress report just submitted estimates that by 1975 some 300,000 fewer women will be served by organized programs than projected in the 1971 5-year plan on the basis that it is expected this additional number of women will be served by private physicians.

On what do you base this assumption?

Dr. SHULTZ. That assumption is based on information which we had available from two studies which were not available at the time of the original 5-year plan. It indicated that private physicians were supplying services in larger numbers than we had originally projected.

Therefore we assumed that we were making a correct projection in assuming that more women would receive services from private physicians than was originally estimated.

Senator CRANSTON. What program authorities will provide for reimbursement of these physicians?

Dr. SHULTZ. Title IV (a) and title XIX, particularly title XIX, will provide for reimbursement of these physicians, and apparently is providing for such reimbursement.

Senator CRANSTON. In regard further to the updated plan that we received yesterday, page 24 states:

The individual State plans under Medicaid will determine the goals and priorities for family planning services within each of the States. This aggregate of State and local activities will constitute the nationwide program.

Does this new policy not mean that HEW is throwing out the national goals, which the President established in 1969, of providing family planning to all those who want them but cannot afford them—6.6 million women?

Dr. SIMMONS. No, sir, it does not. The President has said that it continues to be a national goal to provide assistance to those who want but cannot afford family planning services. What we are saying is we think those locally and at the State level can better make that judgment than we can here in Washington. This is why it is being proposed that the judgment be made there.

As Dr. Hellman pointed out, we continue to provide the project grant funds which provide a cushion in those specific areas that may be slow in catching up and in areas where some disadvantaged will not have services available without them.

Senator CRANSTON. Do you specifically say that you are standing by the avowed goal of the President to provide services for all those who want them but cannot afford them?

Dr. SIMMONS. We are standing by that statement; right. I would point out that that is not 6.6 million women. It may be a different figure, and it is probably lower.

Senator CRANSTON. On page 25 it says that you regard a county as "covered" if facilities are located within normal commuting distance in adjacent counties. What do you mean by that, 30, 40, 50 or 60 miles?

Dr. SHULTZ. That was determined by the individual regional office in cooperation with the State health agency which was requested to work with the regional office in determining whether or not a county was covered, so it would vary geographically. There would be no specific standard nationwide. It would vary within individual States.

Senator CRANSTON. Is that distance to be covered by car?

Dr. SHULTZ. It would be determined by the standard which was set by the State and regional offices.

Senator CRANSTON. We are talking about 50 or 60 miles in some cases I presume?

Dr. SHULTZ. I would assume, yes, sir, we could be speaking of fairly considerable distances in certain areas.

Senator CRANSTON. In view of research findings that geographical proximity promotes continuity of clinic attendance and contraceptive practice, do you think it is realistic to expect women to travel 50 or 60 miles for family planning services?

Dr. SIMMONS. Well, yes. We turned it around and we say that it might be unrealistic and impossible to achieve any services, any closer than that. You do have to staff them, you do have to attract professionals.

What we are saying is we think we are close to that point where for financial reasons, for reasons of inability to attract professionals competent to provide the care, et cetera, we have achieved about what we can.

There may be isolated instances where that is not so.

Dr. SHULTZ. There have been studies to indicate that people will go long distances to obtain their health care services and that this is more satisfactory to them than providing the services within a limited geographic area. They prefer a wider range of selection than could be made available within rural counties when it was attempted to set up a specific health service. There is a long history to justify this approach, and the approach appears to be responsive to the desires of individuals.

Senator CRANSTON. Table 3 in the update shows three levels of estimated need: below poverty, below 125 percent of poverty, and below 150 percent of poverty. The original 5-year plan used the 150-percent level to define need. Why do you now submit the lower estimates? Has HEW abandoned the objective of serving all those who are below 150 percent of poverty before 1975?

Dr. SHULTZ. This was never an established objective. It was a planning estimate, something within which one might work. A number of events have transpired since the submission of the original 5-year plan. Among these was the publication of the regulations for project grants which established a level below which no charge might be made at approximately 135 percent of the poverty level.

In addition to this, it was recognized that there were other factors operative, so that for planning purposes it becomes more desirable to show a wider and broader range, so that the estimation of program accomplishment can be keyed to whatever the mix of goals may be.

Senator CRANSTON. As you know, S. 1708 calls for use of the Bureau of Labor Statistics lower minimum budget level, which is \$7,214 per year, to define low income for family planning purposes. We did that in response to demands from many communities that many people in the marginal income ranges also need voluntary family planning services, particularly to avoid dependency.

What is HEW's attitude toward this issue?

Dr. HELLMAN. Our clinics really have no means test for entrance. An individual can come into a clinic and be unable to pay anything, and be financed either through medicaid or some other means of support. But an individual can attend one of our clinics and can pay part or

totally for his care. There is no restriction in any of our centers for entrance.

Senator CRANSTON. I have some further questions on the progress report on implementation of the plan that I will submit to you as well as on the effects of programs under title V of the Social Security Act. [The information subsequently supplied follows:]

Additional Questions Requested by the CommitteeI. Five-Year Plan Progress Report

- A. On page 33 of the second progress report on the Five-Year Plan, Table 8 shows that almost all patients presently in programs have incomes below twice the poverty level. Why shouldn't we use that level for planning and eligibility? Shouldn't the Federal Government assist these people of low or marginal income to avoid the dependency which comes from unwanted births?

Public Health Service Act project grants and Social Security Act Title V formula grants to States will be available to provide family planning services to many of those not eligible for either Title IV-A or Title XIX assistance.

- B. On page 32, you say that about 1.9 million women below 150 percent of poverty were served in organized programs and 1.2 million by private physicians in 1972. On page 27, you indicate that the need estimate in 1972 was 6.2 million women below 150 percent of poverty. That means that the President's goal was about half accomplished then. Wouldn't you say that this has been a remarkably successful program? Why then do you propose to phase out the project grant mechanism which has generated this success?

Yes, the program has been very successful. By the end of FY 1972, subsidized family planning services were available to residents in 2,379 of the 3,099 counties and districts in the United States. These subsidized services were available to them either in their own county or through facilities in adjacent counties. Organized programs served about 2,612,000 patients in FY 1972, three-quarters of

whom were estimated to have incomes below 150 percent of poverty. Another 1,238,000 low-income women are estimated to have secured family planning care from private physicians in FY 1972.

The Administration has requested a significant amount for project grants in FY 1974.

- C. Page 38, table 11 shows that if organized programs increase and serve 4.9 million women by 1975, the national goal could be achieved. How does the rate of growth shown in table 11 compare with the program's actual rate of growth from fiscal years 1968 to 1972?

The rate of growth estimated in table 11 is the same as that estimated for organized programs during fiscal years 1971 and 1972. However, the national goal is now the aggregate of State and local programs.

II. Funding Levels

- A. Page 52, table 20 shows \$145 million as the Federal share of FY 1973 costs excluding Medicaid. But page 44 states that the National Center has only \$98.5 million to obligate for project grants in 1973, and page 59 says that the MCH Service has \$16.2 million. What are the sources of funding of the remaining \$30.3 million?

The funding sources for the Federal share in FY 1973 are as follows:

<u>Source</u>	<u>Amount</u>
NCFPS	\$97 million
MCHS	14 million
OEO	10 million
*SRS	<u>23 million</u>
Total	\$144 million

*Includes Medicaid reimbursements to organized programs.

- B. Page 54, table 20 also shows \$42 million as the non-federal share. Page 52 mentions that the information was secured from "discussions with state officials." We have had testimony that the maximum currently available from private contributions is \$15 million and from state and local governments \$5 million. How do you reconcile these figures? Are your data based on records of actual expenditures?

Our estimates are based on the best information currently available to Regional Family Planning Directors.

- C. Page 58, table 25 purports to estimate the total costs, but the figures don't match the program targets shown in table 11. For example, the \$365-395 million shown for services in 1975, at \$66 a patient, would pay for services to 5.5 to 6.0 million women, while table 11 shows the targeted service levels in 1975 at 6.6 million. How do you explain this discrepancy?

Table 25 assumes that average cost per patient will be less than \$66. The average cost per patient is expected to range between \$55 and \$60.

- D. Pages 65-66, tables 29 and 30 purport to show the estimated number of patients receiving services under Title IV(A) and the estimated dollars to be spent under Titles IV(A) and XIX. How were these figures derived? Please submit for the record a detailed statement of the methodology employed, the record keeping systems on which the data are based, the detailed information secured from the states, and the basis of the 1973-74 projections. We have received testimony that Title IV(A) financing of family planning services has been limited to a few states and that the new regulations issued by HEW this month will cut back the use of this resource even further. If these statements are true, this report's section on Title IV(A) seems quite misleading. Therefore, the Subcommittee wishes to see exactly how those estimates were prepared.

Title XIX

Before the enactment of Public Law 92-603, Federal expenditures for family planning services were projected at \$6.5 million in FY 1971, \$8.7 million in FY 1972, and \$10.6 million in FY 1973. It should be noted that family planning services were not a mandatory Medicaid service and were not a specifically reported line item in either States' estimates of their Medicaid expenditures (OA-25 Report) or in their statistical reporting to the National Center for Social Statistics (NCSS B-1, B-4 Reports). The estimates for FY 1971-73 are therefore projections based on a combination of NCSS cash assistance and Medicaid population data and the findings of the 1971 AFDC Study.

Better estimates and statistical reporting should be available from FY 1974 onward due to modifications in the forms noted above to account for the change in the status of family planning brought about by PL 92-603.

Total expenditures are projected at \$26.6 million in FY 1973 and \$34.0 million in FY 1974, with the Federal share \$22.4 million in FY 1973 and \$30.6 million in FY 1974.

Section 299E of Public Law 92-603, providing mandatory coverage of family planning services with 90 percent Federal matching, is expected to increase utilization and expenditures for family planning services. Prior to the passage of Public Law 92-603, total expenditures for family planning services under Title XIX were projected at \$19.3 million in FY 1973 and \$21.0 million in FY 1974. It is expected that a 50 percent increase in utilization will result from passage of Public Law 92-603. Since the mandatory coverage and 90 percent matching are effective for less than a full year in FY 1973, only three-fourths of the 50 percent yearly increase is projected for FY 1973. With FY 1974 being the first full year of mandatory coverage and 90 percent matching, the

trend towards increased utilization and expenditures can be expected to continue. This raises projected expenditures for family planning services to \$26.6 million in FY 1973 and \$34 million in FY 1974.

Table 1 shows the estimated expenditures and recipients of family planning services from FY 1970 through FY 1974. The parallel increases in recipients and payments for FY 1973-74 are due to an increase in availability and utilization of services resulting from Public Law 92-603. The Federal share of payments shows the greatest percentage increase, because in addition to increased utilization, Federal matching is raised from 55 percent to 90 percent of total expenditures. For FY 1973, the Federal share averages to 83 percent because the increased matching is not effective until November.

The greatest increases are projected for fiscal year 1973, with recipients up 57 percent and payments up 68 percent. Even prior to Public Law 92-603, an increased emphasis by States on making family planning services available was expected to produce a 22 percent increase in expenditures. With the passage of the Social Security Amendments, family planning was changed from an optional to a mandatory service, and Federal matching was increased from an average of 55 percent to 90 percent. This is expected to produce an immediate jump in recipients and payments in FY 1973, with a significant but somewhat similar increase expected in FY 1974.

Table 1

Title XIX Family Planning Services

	Recipients		Payments (in millions)			
	Total	% Increase	Total	% Increase	Federal Share	% Increase
1970	270,000	---	\$11.1	---	\$6.1	---
1971	280,000	4%	\$11.8	6%	\$6.5	7%
1972	350,000	25%	\$15.8	34%	\$8.7	34%
1973	550,000	57%	\$26.6	68%	\$22.4	157%
1974	700,000	27%	\$34.0	28%	\$30.6	37%

Title IV-A

Prior to June 1973, estimates of the family planning program financed through Title IV-A were based upon the following information:

- (1) "Characteristics Studies" which provided data on the number of public assistance recipients receiving family planning services.
- (2) Informal estimates from States and other organizations as to cost per recipient for family planning under these programs. Even less information has been available for estimating the amount of family planning program directed to former and potential recipients of public assistance.

Realizing the information base for making acceptable estimates for family planning was adequate, SRS took action to get estimates from the States on their family planning expenditures by including this item in the requirements for expenditures estimates reported on the SRS-OA-25 "Forecast of Expenditures." Preliminary estimates submitted on this document indicate that SRS had underestimated the funds going into this program. To date SRS has received estimates of expenditures of Federal funds from 17 States which total \$13,968,900 for FY 1973, \$23,559,400 for 25 States for FY 1974, and \$24,316,100 for 25 States for FY 1975.

A listing of Title IV-A family planning estimates by the States can be found on Table I. Please note that only two of 25 States reporting (Illinois and North Carolina) indicate a decrease in their family planning program in 1974.

Table II displays the unit costs for family planning under Title IV-A, the rate of Federal financial participation under Title IV-A, and the interface of Title IV-A with the Title XIX family planning program.

Table III provides an overview of the method used in calculating current estimates. During the upcoming year, data will become available for making more precise estimates. Data received on the May 1973 SRS-OA-25 estimates from the States (Table I) indicate that SRS estimates are probably conservative.

Table I

**Title IV-A Family Planning -
Estimated States' Expenditures of Federal Funds**

<u>TOTALS</u>	<u>FY'73</u> <u>\$13,968,900</u>	<u>FY'74</u> <u>\$23,559,400</u>	<u>FY'75</u> <u>\$24,316,100</u>
Alabama	*	*	*
Alaska	*	*	*
Arizona	*	*	*
Arkansas	*	\$1,125,000	\$1,350,000
California	*	*	*
Colorado	*	*	*
Connecticut	\$10,000	23,000	23,000
Delaware	*	*	*
District of Columbia	*	*	*
Florida	*	*	*
Georgia	457,000	1,967,000	1,967,000
Hawaii	*	*	*
Idaho	24,000	58,800	58,800
Illinois	936,000	870,000	(870,000)
Indiana	740,000	1,868,000	1,962,000
Iowa	*	*	*
Kansas	- 0 -	45,000	90,000
Kentucky	*	*	*
Louisiana	8,668,000	10,600,000	10,600,000
Maine	*	*	*
Maryland	*	900,000	900,000
Massachusetts	*	*	*
Michigan	*	*	*
Minnesota	332,000	436,000	458,000
Mississippi	*	*	*
Missouri	368,000	829,000	837,000
Montana	*	*	*
Nebraska	*	*	*
Nevada	*	50,000	50,000
New Hampshire	*	*	*
New Jersey	36,000	45,000	54,000
New Mexico	*	87,000	216,000
New York	1,215,000	1,215,000	1,215,000
North Carolina	246,000	45,000	45,000
North Dakota	107,900	127,600	148,300
Ohio	*	*	*
Oklahoma	118,000	118,000	118,000
Oregon	*	*	*
Pennsylvania	*	1,000,000	1,000,000
Rhode Island	6,000	15,000	10,000

(Continued)

	<u>FY'73</u>	<u>FY'74</u>	<u>FY'75</u>
South Carolina	*	\$ 200,000	\$ 400,000
South Dakota	*	100,000	(100,000)
Tennessee	*	*	*
Texas	\$ 450,000	1,236,000	1,236,000
Utah	255,000	320,000	320,000
Vermont	*	279,000	288,000
Virginia	*	*	*
Washington	*	*	*
West Virginia	*	*	*
Wisconsin	*	*	*
Wyoming	*	*	*
American Samoa	-	-	*
Guam	*	*	*
Puerto Rico	*	*	*
Trust Territory	-	-	*
Virgin Islands	*	*	*

* Not Reported

Parentheses indicate estimates made by SRS rather than the States.

Source - May 1973 SRS-QA-25 - Projection of Expenditures

Table II

Title IV-A Unit Costs, Rate of Federal Participation, and Interface with Title XIX

	<u>FY 1972</u>	<u>FY 1973</u>	<u>FY 1974</u>
I. Program and Expenditure Levels			
Total Expenditures (Fed.-State-local)	\$24,667,000	\$25,889,000	\$35,000,000
Federal Share	18,500,000	21,400,000	31,500,000
State and local	6,167,000	4,489,000	3,500,000
Recipients of Service	925,000	1,100,000	1,750,000
Unit Cost per Recipient (Fed.-State-local)	\$ 26.67	\$ 23.54	\$ 20.00
Federal Share	20.00	19.45	18.00
State and local	6.67	4.45	2.00
(8) Rate of Federal Participation	75%	83%	90%
II. Purchased Medical Services for Family Planning (Amounts Included Above)			
Total Federal State and local	6,167,000	3,883,000	3,500,000
Federal Share	4,625,000	3,210,000	3,150,000
State and local	1,542,000	673,000	350,000
Rate of Federal Participation	75%	83%	90%
III. Interface with Title XIX			
Estimated Purchased - no change in pattern	4,625,000	6,050,000	10,500,000
Average Cost Per Recipient Receiving Any or All Family Planning Service	5.00	5.50	6.00
Impact of Closed-end Appropriation and New Social Service Regulations (Increase to Title XIX)	---	-2,840,000	-7,350,000
Net Purchases Under Social Service	4,625,000	3,210,000	3,150,000

Table III

**Method Used in Computing
Family Planning Estimates for Title IV-A**

Step I - Public Welfare Cases in FY '72

(a)	Average monthly number of money payment cases	2,918,000
(b)	Estimated new money payment cases during the year	1,546,000
(c)	Total cases on-board during FY '72	4,464,000
(d)	Percent of cases at one point in time which were receiving or had received a family planning service during the year	

Current Cases	21.0%
New Cases	10.5%

The above estimates are based on 1971 Characteristic Study which showed that on January 1, 1971 the percent of cases on-board had received or were receiving family planning:

18.2% F.P. service without medical referral
10.5% F.P. service with medical referral

(e)	Number of money payment cases receiving family planning	
	Current Cases	613,000
	New Cases	162,000
		<u>775,000</u>
(f)	Unit cost per case (estimate based on telephone survey of selected States by our Regional Offices)	\$20
(g)	Federal expenditures for money payment cases	<u>\$15,500,000</u>

Table III Cont'd.

Step II - Former and Potential Cases in FY '72

(a) Total Federal expenditures	\$18,500,000
(b) Less money payment cases	\$15,500,000
(c) Amount expended on former and potentials (a) minus (b)	<u>\$ 3,000,000</u>
(d) Number of cases receiving family planning ((c) ÷ by unit cost \$20)	<u>150,000</u>

Step III - Summary

	<u>Number of Persons</u>	<u>Amount in Dollars</u>
Current money payment recipients	775,000	\$15,500,000
Former and Potentials	<u>150,000</u>	<u>3,000,000</u>
Total FY '72	925,000	\$18,500,000

Changes in Method for FY '73 and FY '74

Basically the same format for estimating FY '73 and FY '74 was used with allowance for changes in Federal financial participation, impact of the mandatory provision in the legislation and the impact of new regulations. These changes are indicated on Table II.

- E. Page 66, table 30 shows an estimate of \$52.5 million under Title IV(A) and XIX for family planning services this year. Those figures are also carried in the FY 73 budget, aren't they? Since they are included in the budget as expenditures, I assume that HEW has no objection to their being spent. Would HEW object if Congress directed that these sums be transferred from SRS to the National Center and spent for family planning services?

The \$52.5 million for family planning services under Titles IV-A and XIX is only the amount estimated to be expended for these programs. Family planning funds under Titles IV-A and XIX are not separate appropriations. Fund control is at the appropriation level for all Title IV-A and XIX programs.

- F. Page 67, we would also like for the record the detailed data from the states on which the estimates in table 31 are based and information on the record-keeping systems underlying these estimates.

Table 31 is based on the same information as are tables 29 and 30 cited in item II D above.

- G. Do you have an estimate of the proportion of total income which family planning programs now derive from third-party reimbursements?

This information is not available.

- H. Of this percentage how much do you estimate is derived from Medicaid and how much from Title IV(A)?

This information is not available.

- I. 1. Do you have an estimate of how much of the income of neighborhood health centers providing comprehensive health services is derived from third-party payments such as Medicaid, Title IV(A) and Medicare?
2. Do you think this figure can serve as a guide to the optimum amount which could be expected from reimbursements under Medicaid and Title IV(A) if all states utilized Medicaid and Title IV(A) fully?

This information is not available.

III. Social Security Act Title V

- A. Could you tell me what is the current level of expenditures under the Sec. 508 special project grants for family planning services authority of Title V of the Social Security Act? About how many patients are served under this authority?

FY 1973 obligations for Sec. 508 special project grants are estimated at \$23.5 million, \$4.5 million of which is administered by the Maternal and Child Health Service and \$19 million by the National Center for Family Planning Services. This will provide services for approximately 120,000 patients in Maternity and Infant Care Projects administered by the Maternal and Child Health Service and 316,000 patients in NCFPS programs.

- B. Could you tell me what is the current reported level of expenditures for family planning under the Sec. 503-formula-grants-to-the-states-for-maternal-and-child-health-authority of the Social Security Act? About how many patients are being reported?

FY 1973 obligations for family planning services under Sec. 503 formula grant authority are estimated at \$11.7 million. An estimated 867,000 patients will be served.

- C. I understand that these figures advanced by HEW for the M.C.H. state programs are estimates. Could you tell me how they compare in accuracy with the levels of services reported either through the National Uniform Reporting System or through the county studies which have been conducted by the Department?

The figures are supplied by individual State MCH programs. Some of the clinics in these programs participate in the National Reporting System.

- D. With regard to this reported patient figure through S.S.A. Title V programs, since many of the Title X project grant awards are made to state health agencies, isn't it possible that some of the one million patients they are reporting are actually being provided services through Title X project grant programs rather than through M.C.H. formula grants.

Since many State health agencies receive funds from a number of sources, it is possible some duplication occurs in reporting numbers of patients served.

- E. Is it also possible, since the state M.C.H. division of the health departments are responsible for supervision of family planning services, that in their estimates states may include services provided by O.E.O. through local hospitals, or even through Planned Parenthood?

It is possible.

- F. Under M.C.H. formula grants, when you cite these patient numbers, does it mean that each of the patients served has received a general gynecological examination, a pap smear, lab tests and all the other related health services required in the Title X Federal project grant regulations and guidelines for the provision of comprehensive family planning services?

The services required under Title V guidelines are essentially the same as those under Title X.

- G. Along these same lines, I want to ask you about the future of the Sec. 508 special project grants authority for family planning under Title V of the Social Security Act. I understand that you plan to pick up the costs for these projects under Sec. 314(e) of the Public Health Service Act after June 30, 1973 when they expire, is that correct?

Sec. 508 special project grant authority has been extended through June 30, 1974.

- H. If yes, as I understand Title V of the Social Security Act, when these special project authorities are phased out, the state health agencies, particularly the M.C.H. divisions, are by law supposed to pick up the costs through their increased Title V formula grant funds, isn't that correct?

See item III G above.

- I. Doesn't your transferring the costs of these projects to Sec. 314(e) demonstrate your reluctance to place responsibility for these projects in the hands of the states? Doesn't it demonstrate that you do not think the states would in fact pick up the costs for these projects with their formula grants in funds under Sec. 503, SSA? Doesn't it mean that you still think there is a need for federal level categorical grants for family planning services?

The Administration believes that during fiscal year 1974 there will still be a need for project grants.

IV. 314(e) Authority

- A. The Social Security Act Title V maternal and child health special project grants for family planning authority is slated to expire June 30, 1973, and since Sec. 314(e) also expires June 30, 1973, can you tell me what alternate arrangements you have made for the support of these projects if neither authority has been renewed by that time? Do you propose to continue funding these programs under a continuing resolution?

Sec. 508 special project grant authority has been extended through June 30, 1974.

- B. With regard to Sec. 314(e) there is demonstrated Congressional interest in drastically restricting the use of this section. What kind of arrangements has the Administration made for the continuation of all the special project grants for family planning--whether OEO, Title V or Title X of the Public Health Service Act--should Sec. 314(e) be limited as Congressman Rogers has proposed?

Titles V and X have been extended through June 30, 1974. The Administration has requested an increased authorization in FY 1974 under Title X to fund former OEO family planning projects.

- C. Two excellent programs administered through the American College of Obstetricians and Gynecologists are currently supported by federal project grants, one from OEO and the other from the National Center for Family Planning Services. It is my understanding one of the great values of the two projects is that they are repeated in different regions of the country so that their effectiveness can be measured under varying circumstances.

Without the national direction provided by the National Center for Family Planning with supervisory responsibility, could these programs effectively achieve their goals?

The NCFPS currently administers such grants. During FY 1974, funds are being transferred to the NCFPS to support 200 projects currently administered by OEO. All grants, including the ACOG grant, will be re-evaluated in terms of current program priorities prior to refunding by NCFPS.

Senator CRANSTON. In regard to research issues, Dr. Hellman, I had intended to ask you questions concerning recommendations made that research in abortifacients should not be supported by the Federal Government. You have answered that by your earlier submission.

Dr. Hellman, as a scientist and medical expert in this, can you tell us, from a medical point of view, what is an IUD?

Dr. HELLMAN. An IUD is an intrauterine device usually made out of plastic that is placed in the uterus as a method of family planning.

Senator CRANSTON. It is an abortifacient device?

Dr. HELLMAN. The mode of action of the intrauterine device is not known at this time. We are spending a fair amount of money on research on the mode of action of these devices.

Senator CRANSTON. Scientifically you cannot conclude at this time that it is an abortifacient device?

Dr. HELLMAN. No, sir.

Senator CRANSTON. How many women in the United States now use the IUD?

Dr. HELLMAN. About 2½ million.

Senator CRANSTON. If this were not a permissible method of family planning, what would be the effect on the programs receiving project grant support?

Dr. HELLMAN. The majority of our patients, about 70 percent, use oral contraceptives. The next most commonly used contraceptive is the intrauterine device. If it were not allowed in our program, I think it would have a serious impact on the program.

The intrauterine device programs abroad are also quite extensive, and I think if the United States stopped using these devices, it would have a very great impact on family planning abroad.

Senator CRANSTON. Is it important to have choices of family planning methods? Does this have an effect on the success of the program?

Dr. HELLMAN. Yes, I think it is extremely important that we offer a broad range of methods to our patients, including rhythm.

Senator CRANSTON. What will be the effect abroad if there is a banning on IUD's?

Dr. HELLMAN. The role of the United States both in contraceptive drugs and in intrauterine devices, and devices in general, is one of leadership. When we improve these drugs or devices, other governments tend to follow what the United States does in this regard.

Senator CRANSTON. It has also been recommended to the committee that section 1008 prohibiting use of title X funds in programs where abortion is a method of family planning be expanded to prohibit use of abortifacient devices and sterilization procedures.

Could you please comment on that?

Dr. HELLMAN. I do not believe at the present time we use abortifacient devices. We are very cognizant of the wishes of Congress in 1008, and also the comments before the House Appropriations Committee in 1972 regarding research on abortion.

My policy and the policy of HEW has been to follow strictly the intent of Congress in this matter.

Senator CRANSTON. You did not comment on the sterilization aspect.

Dr. HELLMAN. Sterilization is an accepted method of family planning. There have been several legal cases in your own State. The Bie-

lenson law which was signed by the Governor of California last year indicates that prohibition of sterilization for other than medical reasons is not acceptable.

In addition, there is currently a case in Shasta County, California, that touches on whether sterilization is a method of family planning.

It is unrealistic, and perhaps medically unsound, to force a couple to use contraceptives after their family has been completed, particularly contraceptives that have a small but real risk involved such as oral contraceptives.

Sterilization is used rather extensively in our program. The information we have for the year 1972 indicates that at least 30,000 women and 10,000 men received sterilization counseling and services through our program.

Senator CRANSTON. How many people in the entire country do you estimate have had sterilization?

Dr. HELLMAN. Current fertility surveys indicate that one out of five couples who have achieved their desired family size has selected sterilization as a means of fertility control.

Senator CRANSTON. What is the scientific definition of sterilization?

Dr. HELLMAN. The scientific definition of sterilization is any operation which would make either the male or the female unable to reproduce. The common operation in the female is ligation of the fallopian tubes. The common operation in the male is vasectomy, ligation and separation of the tubes that lead from the testes and transmit the sperm.

We are now working—and Dr. Corfman has an extensive program—on what is called reversible sterilizations in both the male and female. If you wish for information, I am sure we would be glad to furnish it.

Senator CRANSTON. Would you supply that for the record.

Dr. HELLMAN. Yes.

[The information subsequently supplied follows:]

NICHD RESEARCH CONTRACTS AWARDED
FOR DEVELOPMENT OF REVERSIBLE STERILIZATION
TECHNIQUES AND DEVICES

Contract Number	Investigator and Institution Title	FY 72 (term of contract)	FY 73
<u>For Application in the Male</u>			
71-2223	M. Freund - M.V. Medical College "The Use of a Reversible Vasectomy Device in the Guinea Pig"	\$74,779 (15 months)	
71-2227	E. Nuwayser - Abcor, Inc. "Development of New Sterilization Techniques - Male"	(FY 71) \$344,847 (24 months)	\$65,297 (15 months)
71-2229	E. Brueschke - ITT Research Institute "Design and Development of Implantable Contraceptive Devices for Use in the Male"	\$244,386 (15 months)	
72-2765	D. Kraemer - S.W. Foundation for Research "Reversible Sterilization by an Intravassal Spermicidal Device"	\$57,374 (15 months)	
72-2769	E. Mather - University of Missouri "Development of Evaluation of a Reversible Vasectomy Prosthesis"	\$38,041 (15 months)	
72-2796	T. Robinson - Tecna Corporation "Development of a Reversible Vas- occluding Prosthesis"	\$104,325 (15 months)	
<u>For Application in the Female</u>			
71-2233	E. Brueschke - ITT Research Institute "Development of an Intrauterine Sterilization System for the Female"	\$519,465 (15 months)	
71-2237	R. Erb - Franklin Institute "Device and Technique for Blocking Fallopian Tubes"	\$124,620 (15 months)	
73-3767	S. Kitrilakis - Tecna Corporation "Clinical Evaluation of a Fluid-filled Intrauterine Device"		\$51,850 (12 months)

Senator CRANSTON. Going beyond that, how much of the \$40 million budgeted for population research in fiscal year 1973 was awarded to drug companies?

Dr. HELLMAN. We will submit that for the record.

Dr. CORFMAN. I have it right here. In fiscal year 1973 we had six contracts with industry, Senator Cranston, at about \$600,000.

Senator CRANSTON. Total?

Dr. CORFMAN. Yes, total for all six.

Senator CRANSTON. I understand that a portion of this was allocated to research in pharmaceuticals and a portion to drug delivery systems. Could you explain what these two categories are, and the types of programs supported under each?

Dr. CORFMAN. Surely. Most of those contracts were with industry to synthesize new agents that we intend to test for their antifertility effect. The other categories with industry are to develop methods of delivering drugs to people other than by pills.

Actually we have a third contract which is a testing facility in Massachusetts to test compounds that we develop under our direction. Those are the three purposes of our contracts with industry.

Dr. HELLMAN. A drug delivery system would be something like this. If you impregnate an intrauterine device with hormone to make its action more insured, that would be a different kind of delivery system than taking it by mouth or by injection.

This would have very far reaching effects beyond family planning because there are a lot of drugs that are given either orally or by injection which you would like to give continuously if you could develop a new delivery system, drugs for hypertension, for example.

Senator CRANSTON. Could you provide a breakout of the programs supported under this funding?

Dr. CORFMAN. Industry?

Senator CRANSTON. Yes.

Dr. CORFMAN. Yes.

[The information subsequently supplied follows:]

NICHD RESEARCH CONTRACTS AWARDED TO "DRUG COMPANIES"*

Contract Number	Company	Investigator and Project Title	FY 72	FY 73
9-2208	Upjohn Company, The Kalamazoo, Mich.	K. Kirton - "Luteolysis as an Approach to Contraception"	\$88,140 (24 months)	0
1-2463	Ayerst Research Labs. Montreal, Canada	C. Revesz - "Synthesis and Antifertility Testing of Prostanoid Acid Derivatives"	(FY 71) \$180,640 (24 months)	0
1-2224	Upjohn Company, The Kalamazoo, Mich.	K. Kirton - "Quantification of Prostaglandins"	\$50,247 (15 months)	0
2-2722	Abbott Laboratories North Chicago, Ill.	W. White - "Synthesis and Testing of Gonadotropin Releasing Hormone"	\$125,300 (12 months)	\$7,750 (expiring)
3-2786	Abbott Laboratories North Chicago, Ill.	J. Cole - "Biological Testing of Thyrotropin Releasing Hormone (TRH) to Determine the Extent and Nature of Antifertility Activity"	-	\$83,563 (12 months)

* For lack of other definition, "Drug Companies" includes only those profit-making organizations listed in the Manufacturers Index of the current Physicians' Desk Reference.

NICHD RESEARCH CONTRACTS FUNDED BY THE CPR
WITH PROFIT-MAKING ORGANIZATIONS

Contract Number	Institution	Investigator and Project Title	FY 72	FY 73
<u>FOR DRUG DEVELOPMENT</u>				
1-2224	Upjohn Company, The Kalamazoo, Mich.	K. Kirton - "Quantification of Prostaglandins"	\$50,247 (15 months)	0
1-2463	Ayerst Research Labs. Montreal, Canada	C. Revesz - "Synthesis and Antifertility Testing of Prostanoid Acid Derivatives"	(FY 71) \$180,640 (24 months)	0
2-2717	Hazleton Labs., Inc. Vienna, Va.	D. Dalgard - "Obtaining Synthesizing and Testing Antifertility Compounds"	\$41,100 (15 months)	0
2-2722	Abbott Laboratories North Chicago, Ill.	W. White - "Synthesis and Testing of Gonadotropin Releasing Hormone"	\$125,300 (12 months)	\$7,750 (expiring)
3-2786	Abbott Laboratories North Chicago, Ill.	J. Cole - "Biological Testing of Thyrotropin Releasing Hormone (TRH) to Determine the Extent and Nature of Antifertility Activity"	-	\$83,563 (12 months)
<u>FOR DRUG DELIVERY SYSTEMS</u>				
3-2736	Dynatech R/D Company Cambridge, Mass.	D. Wise - "Development and Testing of an Implantable Contraceptive Delivery System"	-	\$245,972 (24 months)
3-2738	Abcor, Inc. Cambridge, Mass.	E. Nuwaysir - "Implantable Bio- Absorbable Capsules as Slow - Release Contraceptive Drug Delivery System"		\$254,856 (24 months)

page 2

FOR DRUG TESTING

2-2746	Mason Research Institute Worcester, Mass.	H. Rosenkrantz - "Biological Testing Facility"	\$844,057	\$125,000
<u>FOR DEVICE DEVELOPMENT</u>				
1-2227	Abcor, Inc. Cambridge, Mass.	E. Nuwayser - "Development of New Sterilization Techniques - Male"	(FY 71) \$344,847 (24 months)	\$65,297 (12 months)

1-2239	Polysciences, Inc. Warrington, Pa.	D. Halpern - "New Hydrophilic Polymers for Population Regulation"	\$6,942 (expired)	0
2-2796	Tecna Corporation Emeryville, Calif.	T. Robinson - "Development of a Reversible Vas-occluding Prosthesis"	\$104,325 (15 months)	0
3-3767	Tecna Corporation Emeryville, Calif.	S. Kitrilakis - "Clinical Evaluation of a Fluid-filled Intra-uterine Device"	0	\$51,850 (12 months)

FOR MISCELLANEOUS STUDIES

9-2208	Upjohn Company, The Kalamazoo, Mich.	K. Kirton - "Luteolysis as an Approach to Contraception"	\$88,140 (24 months)	0
0-2250	Endocrine Labs of Madison, Inc. Madison, Wisconsin	E. Shipley - "Studies in Rhesus Monkeys Related to the Development of Antifertility Agents"	\$64,688	\$97,190
1-2133	Flow Laboratories, Inc. Rockville, Maryland	J. Haughom - "Growth of Human Trophoblast Cells in Culture"	\$95,540	\$57,621
1-2298	Litton Bionetics, Inc. Bethesda, Maryland	W. Loeb - "Alteration of Thrombogenic Potential by Oral Contraceptive Steroids in Rhesus Monkeys"	\$6,977	\$30,841

2-0092	Litton Bionetics, Inc.	"Collection of Urine from 90 Pregnant Rhesus Monkeys"	\$17,200	0
2-2708	Tracor, Inc. Austin, Texas	D. Price - "Review of Research Findings on Rural - Urban Migration with Annotated Bibliography"	\$30,818	0
TOTAL			\$1,019,940	

Senator CRANSTON. Dr. Hellman, what do you estimate should be appropriated for population research for each of the next 3 fiscal years that can be wisely and effectively spent by the scientific community to develop a safe and effective means of controlling fertility?

Dr. HELLMAN. I do not know that I can answer that question specifically. As you know, Government funded population research is faced with the same budget constraints that research at NIH in general is faced with.

I would like to say this, that the current level of support, both from the Federal standpoint and from the private standpoint, does not prevent in my opinion the funding of any reasonable and promising approach to new contraceptives.

Senator CRANSTON. How much can be provided now by medical research institutions for these purposes?

Dr. HELLMAN. You mean the foundations?

Senator CRANSTON. Yes.

Dr. HELLMAN. Over the past 3 years the three major foundations—Ford, Rockefeller, and Population Council—have supplied about \$20 million annually.

Senator CRANSTON. What about medical research not supported by NIH?

Dr. HELLMAN. I do not think we have any estimate of how much money is put into research by medical schools in this field.

Senator CRANSTON. How much is put in by the pharmaceutical industry?

Dr. HELLMAN. The World Bank is just working on those estimates. They have no definite figures at the present time. This is a very difficult piece of information to get.

Senator CRANSTON. You have an estimate of the numbers of approved applications for research in human reproduction which the NIH Center for Population Research has been unable to fund?

Dr. CORFMAN. In our contract program we fund essentially all that are approved because that is a tailor-made program, and we can design it accordingly. Our grant program is not so designed, and our current funding level of new projects is about 30 or 40 percent.

Senator CRANSTON. Could you give us a list of those?

Dr. CORFMAN. A list of those that are approved and not funded?

Senator CRANSTON. Yes.

Dr. CORFMAN. We can provide that but probably not until the end of the fiscal year.

Senator CRANSTON. If you could provide that, as well as those not funded.

Dr. CORFMAN. Yes.

[The information subsequently supplied follows:]

LIST OF APPROVED BUT UNFUNDED PROJECTS

There are approximately 300 approved but unfunded research grants. The list will be submitted to the Committee as soon as it is available.

Senator CRANSTON. Dr. Hellman, what do you believe will be the impact of the administration's proposal to terminate support of research training grants on research on human reproduction, research in the provision of family planning services, and research in population dynamics?

Dr. HELLMAN. As you know, we were not singled out for termination of training grants. This applies across the board. I think that as a long-term policy this is self-defeating, but as a short-term measure, it will allow us to assess training needs.

We have to assess different methods of training people and examine the question of equity. Should training for scientists be subsidized without subsidizing training in other disciplines?

Dr. SIMMONS. I think we should be clear about the fact the administration is not against research training. Research training is a responsibility of the individual who desires such and the Federal responsibility is to make available scholarship or loan funds.

Senator CRANSTON. Getting to a few general questions, at a hearing before the subcommittee in May—Ms. Randy Engel, executive director, U.S. Coalition for Life, presented the subcommittee with a report which she describes as “replete with necessary documentation which highlights the gross violations of the Tydings Act by governmental and private profit and nonprofit entities.”

I forwarded this documentation to you immediately and asked that the report be reviewed and that you report back to the subcommittee today with comments on the report and advise us of any violation and actions that will be taken to correct them. We received your May 18 letter which certainly is not specific on the allegations.

May I have your response to the allegations contained in this report.

Dr. HELLMAN. Ms. Randy Engel stated in her testimony before you that she had a document of some 200 pages to back up her allegations. The three volumes of documents that you sent me may have added up to 200 pages, but they were a miscellaneous hodge-podge of scientific research, newspaper clippings, and other kinds of writing that had no real bearing on whether there had been violations of section 1008 of the Tydings Act.

I think my letter to you covered these violations, but I will, if you want to go into them specifically, submit them for the record.

For example, she says violations include the establishment of funding of teenage fornication and abortion centers. Now, in the first place I am not sure I understand her English. I do not know what a fornication center is.

Is the word used as an adjective or is it a noun, indicating what we are teaching in these centers? I have looked into the teenage situation, Senator, and I can assure you that this clinic does not violate any section of the Tydings Act or any of the laws of the State of Illinois.

I do not think it is profitable, sir, to go through these allegations one by one, but if you wish me to do so, I will submit them for the record.

Senator CRANSTON. Dr. Hellman, there are wide disparities of viewpoint obviously in this general matter. There are deeply held convictions based on moral and religious and other factors that affect the thinking of individuals in these matters.

Where there are specific allegations that you can understand and specific acts, I think those people in the committee are entitled to a response to them. Where they are general and not traceable to anything you can place your finger on, I can understand your inability to respond, but I think you should respond to specific allegations where

there are such in a document submitted to you; if you would for the record.

Dr. HELLMAN. All right. I really think if you as a lawyer looked at these allegations you would say they are non-specific.

Senator CRANSTON. I am not a lawyer. I think there are specific concerns expressed there. If there are no specific allegations there that you can respond to in any way, then please indicate that to us in writing, but your letter did not respond in that fashion. I realize this is an onerous task, but I think it is necessary to see if there are specific charges that you can answer specifically.

If you could seek the advice of HEW general counsel, perhaps that would be helpful.

Dr. HELLMAN. I sought the advice of HEW general counsel before I wrote you the letter.

Senator CRANSTON. I am afraid we have to go further.

Dr. HELLMAN. I understand, sir. I will do my best.

Senator CRANSTON. I thank you. I realize it is a difficult task to come to grips with.

[The following information was subsequently supplied for the record:]

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United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

May 14, 1973

Dr. Louis Hellman
 Deputy Assistant Secretary of Health
 for Population Affairs
 Department of Health, Education and
 Welfare
 Washington, D.C.

Dear Dr. Hellman:

In presenting testimony before the Special Subcommittee on Human Resources on May 10, Mrs. Randy Engel provided the Subcommittee with a report she described as "replete with necessary documentation, which highlights the gross violations of the Tydings Act by governmental and private and non-profit entities."

I am forwarding Mrs. Engel's report to you for review and comment on the allegations made and would appreciate your providing the Subcommittee with a report at the time of the Department's scheduled appearance before the Subcommittee, May 23rd.

Thank you very much for your cooperation with the Subcommittee.

Sincerely,

Alan Cranston
 Chairman, Special Subcommittee
 on Human Resources

Enclosure

COPY



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

May 18, 1973

Honorable Alan Cranston
Chairman
Special Subcommittee on Human Resources
Committee on Labor and Public Welfare
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

Thank you for your letter of May 14 and for the opportunity to review the testimony of Ms. Randy Engel and the miscellaneous material that she delivered to the Subcommittee on Human Resources on May 10, 1973.

In response to the alleged violations of Section 1008 of the Family Planning Services and Population Research Act of 1970 (P.L. 91-572), I wish to state that DHEW has consistently adhered to Section 1008, namely "that none of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."

Further DHEW has adhered to the intent of Congress expressed in the Conference Report accompanying the FY 1972 HEW Appropriations Act (P.L. 92-80, 92nd Cong., 1st Sess. (1971)) as follows:

The Committee of Conference is agreed that in the population research, the prohibition in Title X of abortion as a method of family planning should not be construed so as to prevent scientific research into the causes of abortion and its effects (H.R. Rep. No. 92-461, 92d Cong., 1st Sess. 8 (1971)).

Page 2 - Honorable Alan Cranston

As Deputy Assistant Secretary for Population Affairs I have investigated all complaints referable to Section 1008 of the Family Planning Services and Population Research Act and will continue to do so.

I would be happy to furnish any additional material you desire.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "L. M. Hellman", written in a cursive style.

Louis M. Hellman, M.D.
Deputy Assistant Secretary
for Population Affairs

HARRISON A. WILLIAMS, JR., N.J., CHAIRMAN
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United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

31
 May 30, 1973

Dr. Louis Hellman
 c/o Dr. John Zapp
 Deputy Assistant Secretary
 for Legislation
 Room 5448
 HEW North Building
 Washington, D.C. 20201

Dear Dr. Hellman:

Mrs. Randy Regal has submitted the enclosed fourth volume of documentation, which she states indicates violations of the Tydings Act. Would you please review this documentation and advise the Subcommittee of your findings and any action that is taken as a result?

I also enclose a covering letter received from Mrs. Regal in which she specifies particular interest in your response to a specific statement made in her testimony regarding an HEW ruling on the rights of physicians to abort women without their full consent and knowledge.

I would appreciate your response by June 15th.

Many thanks for your cooperation with the Subcommittee.

Sincerely,

Alan Cranston
 Chairman, Special Subcommittee
 on Human Resources

Enclosure

COPY



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

June 12, 1973

Honorable Alan Cranston
Chairman
Special Subcommittee on Human Resources
Committee on Labor and Public Welfare
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

Thank you for your letter of May 31 concerning Ms. Randy Engel's questions with enclosure of her "fourth volume of documentation."

Ms. Engel's documentation consists of a mixture of newspaper reports, letters (some of which are from my office), and a few scientific papers. This material does not contain specific charges that HEW has violated Section 1008 of P.L. 91-572. There are several items referring to HEW that deserve comment, however.

Djerassi, C., Bull. Atom. Sci. 9:9, 1972, says "... the Center for Population Research of the National Institutes of Health seems to have found ways of circumventing Section 1008 of the 1970 Family Planning Act." This statement is untrue. All abortion research by the Center for Population Research deals with causes and consequences of abortion in accord with the intent of Congress.

Conference Report accompanying the FY 1972 HEW Appropriations Act (P.L. 92-80, 92nd Cong., 1st Sess. (1971)) states: "The Committee of Conference is agreed that in the population research, the prohibition in Title X of abortion as a method of family planning should not be construed so as to prevent scientific research into the causes of abortion and its effects (H.R. Rep. No. 92-461, 92d Cong., 1st Sess. 8 (1971))."

Page 2 - Honorable Alan Cranston

Oettinger, K.B., *Pregnancy Detection: A Critical Service Link, Family Planning Perspectives*, 3:15, 1971, states: Dr. Daily emphasized that their job was "to expedite and assure abortion service for these patients within the limit of their ability." This "out of context" quotation is misleading. Dr. Daily's complete memorandum of June 2, 1970 is attached. In brief, the memorandum reviews the procedures to be followed by Maternity and Infant Care-Family Planning employees in view of the New York State Law on Abortion. I believe the following statements are germane.

1. The right of medical referral to a legally constituted medical entity is recognized in the Code of Ethics of the American Medical Association. (Section 8 of the American Medical Association Principles of Medical Ethics; section 8 of the Opinions and Reports of the Judicial Council of the American Medical Association.)

2. Pregnancy testing is a recognized service of our family planning clinics.

3. The training of family planning counsellors for municipal abortion clinics had my approval as the only deterrent for recidivism.

In regard to Ms. Engel's inquiry in her letter to you of May 14 concerning an HEW ruling on the rights of physicians to abort women without their full consent or knowledge, I assure you there is no such ruling nor has one ever been considered.

Please be assured of our wish to be of assistance whenever possible.

Sincerely yours,



Louis M. Hellman, M.D.
Deputy Assistant Secretary
for Population Affairs

Enclosure



Maternity, Infant Care-Family Planning Projects
377 Broadway
New York City, New York 10013
Telephone: 966-3528

Office of the Director

June 2, 1970

American Red Cross Auditorium
Meeting
All MIC-FP Employees

On July 1, 1970 the New York State Abortion Law becomes effective. Medical terminations of pregnancy (abortions) will then become a matter of decision solely between a patient and a physician.

Long before the legislation was enacted, the Headquarters MIC staff had spent many hours in group sessions trying to decide on how the legislation could affect our services and what were the logical steps we should take to help implement the law. (The wild rumors arising from these free-wheeling exploratory sessions caused serious concern to a few of you who heard them). Current estimates are that there will be over 60,000 medical abortions performed per year in New York City hospitals with over 30,000 of these in municipal hospitals.

There are 3 MIC-FP activities which we will carry out to help implement the new law. First, all MIC-FP centers will make available pregnancy testing for patients who are uncertain whether or not they are pregnant. (We will not promote increased pregnancy testing, but nevertheless may be swamped by it and may have to designate certain centers in each borough for this service). Some of these patients with positive tests will wish prenatal care and will be registered for that service; others will say they wish an abortion. You are in no way, by word, expression or action, to indicate any medical or moral judgement for or against abortion. Your function is to make an appointment for the patient to be seen by an M.D. in the back-up hospital, or, if you know the back-up hospital cannot make an appointment for a prospective abortion patient's examination within two weeks (or earlier in an emergency, for a pregnancy between the 12th and 20th week) call the Clearing House, which I will describe later, and have the Clearing House staff make an appointment with another hospital - before the patient leaves your health center. Your job is to expedite and assure abortion



City of New York Department of Health

service for these patients within the limit of your ability. We believe the chief clerk in each center is the most logical person to handle appointments with the back-up hospital or through the Clearing House.

We consider making hospital appointments for prospective abortion patients in the same category as making appointments for deliveries or for diagnostic tests (as we do at present for prenatal and family planning patients).

The performance of abortions is not a part of our maternity program - it is a function of M.D.s and their staff in the hospitals of New York City. Therefore, MID will not become involved in social or health counseling of these patients, as that should be done by hospital staff.

We will have literature discouraging patients from seeking abortions, as many do now, from non-hospital connected sources. We hope the "ladies down the street" who currently perform thousands of abortions each year under very unsafe conditions will become a thing of the past.

If any of you have any hesitancy in dealing with prospective abortion patients, under the policy of patient referral I have outlined, I request that you promptly discuss with your supervisor the pros and cons of continuing employment in MIC-FP. This is the same feeling I have expressed about employees who wish to pass moral judgement and look down their noses at teenage unmarried girls seeking prenatal or family planning services.

The second activity we will carry out is the selection, training and assignment of additional peer level family planning counselors for 15 municipal hospitals who have stated they will have an abortion service. These new counselors will join with the counselors already on duty in municipal hospitals to extend pre-operative family planning service in the O.P.D.s for all prospective abortion patients - as they are now doing for post-partum and post-abortion and other in-patients. Since most abortion patients will not be admitted to the hospitals but will have their operations performed in a 3-5 hour stay, for operation and convalescence - it is urgent that family planning counseling be done prior to the operation. Many of them may wish an IUD or a tubal ligation at time of surgery. The counselors will give return appointments for family planning, either in the hospital or in health department clinics as they do now for in-patients.

You may have read that the Department of Hospitals has already allocated \$3,500,000 to the municipal hospitals in amounts related to the volume of service each expects to provide in the next 12 months. These funds will pay for the physicians, nurses and other personnel needed and for equipment.

The Department of Hospitals and more recently, the Voluntary Hospital Assn. of Greater New York has requested our program to establish and maintain a Clearing House

-3-

for prospective abortion patients. It is anticipated that some hospitals will have more applications or referrals than they can promptly take care of. The Clearing House staff, at 40 Worth Street, will determine each morning the availability of appointments for patients in each hospital and will receive calls from hospitals which cannot handle the caseload. The Clearing House staff will promptly make appointments in a hospital that is not overloaded and so advise the patient through the hospital (or Health Department clinic) where she sought service. The entire purpose of the Clearing House is to expedite care for prospective patients and avoid the discouraging procedure of having to shop around from hospital to hospital.

The Clearing House will have its own private telephone lines and will not be using our switchboard. No calls will be taken from any patient - only from designated hospital staff and from staff in MIC-FP centers. The Director of the Clearing House has been appointed and staff are being recruited to handle the telephone lines and to make the hospital appointments for patients. The difficulties of guess-estimating the demands on such a center are many - we may easily underestimate or overestimate. Funding for the first year of the Clearing House was, fortunately, obtained from a Foundation concerned with the successful implementation of the new Law and most concerned that low-income women, historically denied abortions by New York City hospitals, would now have access to this service.

In closing, may I say that I, and many others in the United States, consider the abortion problem the combined result of the failure to reach all women in the U.S. with accurate information about family planning; the failure to provide family planning services to all women of childbearing age in the U.S. who desire such service; the failure, as yet, to perfect methods of family planning which are safer and more acceptable to women needing such service. If we ever overcome these three omissions, there will be little or no need for abortion services.

Senator CRANSTON. The newspapers on Monday carried stories regarding DHEW proposals for national health insurance. Could you describe the current status of these proposals.

Dr. SIMMONS. We, as you know, Mr. Chairman, are currently spending a great deal of time developing the national health insurance proposal. We are not ready to comment publicly on specific parts of it. We do intend that family planning will be addressed by that proposal in a sufficient manner.

Senator CRANSTON. On Monday proposed regulations were published in the Federal Register governing the implementation of a new funding policy for health services delivery projects supported with funds administered by the Health Services and Mental Health Administration.

Among the specific programs mentioned as being affected by these regulations was family planning, section 1001 of the Public Health Service Act.

The regulations require that an approvable application must describe how the applicant intends to transfer "constructively within a specific time period to other funding sources and eventually to become self-sustaining."

How do you intend to specify this time period in the case of family planning project grants?

Dr. SIMMONS. I do not have a specific answer for you for that, Mr. Chairman. I would be glad to try to provide it.

Senator CRANSTON. How do you see these regulations affecting organized family planning programs currently receiving grant support under title X?

Dr. SIMMONS. That again I would have to provide, Mr. Chairman. [The information subsequently supplied follows:]

PROPOSED REGULATIONS ON HEALTH SERVICES FUNDING

On June 27, 1973, Secretary Weinberger stated before the Senate Subcommittee on Health, Committee on Labor and Public Welfare, that the proposed regulations would be modified in order to take comments received into consideration.

Senator CRANSTON. What would be the effect?

Dr. SIMMONS. There are two different things I believe you are addressing. The newspaper article you are referring to referred to research funds. The grant problem you are talking about is service fund. I am not quite clear what the question is.

Senator CRANSTON. I am referring to the proposed regulations that appeared in the Federal Register on the implementation of new funding policy. I will submit the question for the record if it is not clear to you.

Dr. SIMMONS. We will be glad to provide that for the record, too, Mr. Chairman.

[The information subsequently supplied follows:]

Additional Questions on Proposed
Regulations on Health Services Funding

1. These regulations also state that, in addition to other requirements and conditions imposed by law, an approvable project must provide:

"Except in cases of persons unable to pay therefore, that charges shall be made for all or certain listed services rendered, such services to be in accordance with lists approved by the Secretary, and such charges to be in accordance with schedules approved by the Secretary which schedules may be based on the provision of services on a prepaid capitation basis; provided, however, that to the extent that payments will be made by third party (including a Government agency) which is authorized or under a legal obligation to pay all or a portion of such charges, effort must be made to obtain such third party payment."

I would assume that under your proposal to fund family planning projects under Section 314(e) these regulations would apply.

2. Again, we would face the questions we discussed last year of how one determines who will be charged for services and if a means test will be applied.

What are your expectations in this regard?

On June 27, 1973, Secretary Weinberger stated before the Senate Subcommittee on Health, Committee on Labor and Public Welfare, that the proposed regulations would be modified in order to take comments received into consideration.

Senator CRANSTON. Dr. Hellman, the second updated progress report estimates that about 4,000 additional physicians will be needed in nonmetropolitan areas by fiscal year 1975, and suggests an alternative approach may be to utilize specially training nurse practitioners or other physician equivalents under medical supervision to provide medical services in uncomplicated cases.

Can you tell me what programs are supported now to train needed staff members?

Dr. HELLMAN. Yes. I cannot tell you them all, and I can submit them for the record.

Senator CRANSTON. Would you indicate under what authorities you plan to train these individuals in the future with the projected phase-out of the Nurse Training Act and other health training authorities?

Finally, how many programs do you plan to support under various authorities.

We will submit those questions to you, and some further questions on these points.

[The information subsequently supplied follows:]

Questions Regarding Training Submitted by the Committee

1. a. How many programs do you plan to support to meet your own projected needs for trained personnel by 1975?
- b. Please specify which authorities will be used to provide this support and to what extent each will be used.

The family planning training strategy is to encourage the maximum effective utilization of all categories of personnel through intensive short-term training designed to update existing skills, to introduce new ones, and to develop new job categories. The cost of providing comprehensive training to all family planning clinic staff, whether full or part-time, would be prohibitive and the \$3 million available under Title X for training grants and contracts is being utilized to meet training needs by concentrating on a network of training facilities across the country with a mix of training approaches and methodologies. These training activities were initiated two years ago in 1971 with \$1 million in training contracts. In FY 72 the same level for contracts was continued with an additional \$2 million available for training grants. The training objectives are presently being implemented through FY 72 funding to 23 grantees/contractors on a national level with three primary focuses:

To provide direct training through regional training centers or state and/or local training sites;

To provide specialized training to update the roles of occupational specialties in family planning such as physicians and nurse-clinicians and to develop such new categories as family planning specialists;

To provide a training capacity in those areas where a professional staff trainer is not available and to broaden the range of training by a train-the-trainer methodology.

2. The second update report also describes the need for "clinic supervisors" as being about 1,000 clinic supervisors in metropolitan areas, and 1,875 in non-metropolitan areas, with a least 400 full-time agency administrators needed.
 - a. What authorities do you plan to utilize to provide training for these staff positions?
 - b. How much funding do you estimate will be required by the federal government to support such training programs?

Title X authority, which has been extended through June 30, 1974, will be utilized for the training of a full range of staff personnel of family planning clinics with priorities established to meet special job category needs on both a regional and local basis. With the \$3 million requested by the Administration for FY 1974, the NCFPS training strategy can continue to stress the development and expansion of a mix of training approaches and at the same time give special attention to occupational categories in family planning services where there is a need for intensive short-term training.

3. The same update report also projects a need for 4,902 nurses.

- a. With the projected phase out of training for nurses, how do you see these needs being met by 1975?

As noted on page 41 of the second update report, the current supply of nurses appears to be adequate if currently inactive nurses are utilized in part-time positions.

4. A projected need of some 13,000 outreach workers is reported as well as almost 10,000 clerk aides.

- a. Under what authorities will federal support be provided for the training of these staff members?
- b. How much funding is allocated for this purpose for fiscal years 1974 and 1975?

Title X authority will be utilized. As noted on page 43 of the second update report, the estimates provided are based on very fragmentary information about current staffing patterns and can only be regarded as suggestive of the numbers and types of manpower needed. The estimate for outreach may not prove realistic, particularly because emphasis appears to be shifting away from recruitment in some programs. Some of the communication about contraception for which outreach workers are especially trained and qualified is also now publicized in the media. Within total funds available, priorities will be assigned to full-time workers in FY 1974 and 1975.

5. Do you have plans to provide for continuing education programs for health personnel in the family planning field?

NCFPS emphasizes short-term training programs and currently has no plans to finance continuing education programs.

Senator CRANSTON. I know you have been a leader, Dr. Hellman, in encouraging the use of the nurse-midwife in family planning programs. Could you tell me if programs which utilize nurse-midwives have been able to demonstrate an increased capacity to provide services due to the use of these specialized personnel?

Dr. HELLMAN. I think there is no question about this. I think that contrary to the opinion that existed a few years ago where organized obstetricians and gynecologists opposed these programs, the American College of Obstetrics and Gynecology supports the nurse practitioner program and other such programs.

We have had spectacular success in Brooklyn, as you know, and in Mississippi in the delta area.

Senator CRANSTON. Could you tell me what the costs on the average are of training nurse-midwives and the duration of the training?

Dr. HELLMAN. Basic training is 8 months for a nurse-midwife, and once a nurse-midwife in the United States is trained, the additional training in family planning that she gets does not take more than a month at a maximum. Most of the time about 3 weeks.

Senator CRANSTON. Could you briefly outline the duties of the nurse-midwife?

Dr. HELLMAN. Yes. The nurse-midwife works under the direction of a physician, most often an obstetrician or gynecologist, usually in a medical facility that is a hospital or an outpatient clinic or some sort of medical facility.

She is able to supervise all the aspects of both prenatal and post-partum care and conducts labor and delivery. She is also able to work in the nursery and take care of newborn babies. She provides all aspects of family planning care, including patient counseling and education.

Senator CRANSTON. How much Federal money is being spent on training for this promising type of health professional?

Dr. HELLMAN. The last time I looked at it it was in excess of \$1.5 million.

Senator CRANSTON. Is that enough?

Dr. HELLMAN. It would depend on how well current funds are utilized.

Senator CRANSTON. What is your estimate of what could be effectively allocated for this purpose?

Dr. HELLMAN. Senator, I will try to submit this for the record.

[The information subsequently supplied follows:]

Since this field is expanding, it is difficult to make precise estimates. This training must be evaluated in relation to other training priorities.

Senator CRANSTON. I understand Mr. Bogan of the Office of Education is present. Although I have been asking for about a year and a half for a list of all those environmental education programs supported by the Office of Education which include a population component, I have not yet received it. Senator Packwood, however, has provided me with a list he recently received from Dr. Ottina.

This list shows that only 9 percent of your fiscal year 1972 projects included any identifiable material on population. Why has the performance fallen so far short of the projections made by Commissioner Allen that most projects would include population components and the statement by Dr. Davies that population is an inescapable part of the environmental crisis?

Is there a list of projects that have identifiable population components? That is what I was speaking about.

Mr. BOGAN. I have three projects that I suggest to you. They are broken out in the report that you received.

Senator CRANSTON. Can you make that report available to the committee?

Mr. BOGAN. Yes, indeed.

Senator CRANSTON. There are two lists. There is a synergy list which I think maybe you are talking about and a list of those with an environmental impact. That is what I am talking about.

Mr. BOGAN. We are still not clear because there are obviously two pieces. Let me suggest here that in fiscal 1972 there were three projects that came in that synergy package that were specifically population education totalling \$370,000.

Senator CRANSTON. Do you have a list of environmental education programs showing that only 9 percent of your projects included any identifiable material on population?

Mr. BOGAN. Yes. I think the point that needs to be appreciated is that 9 percent appears to be a small number only if you look at the total number of proposals received instead of the number that sought to address population.

Senator CRANSTON. Would you submit that list?

Mr. BOGAN. Yes, we will.

[The information subsequently supplied follows:]

Fiscal Year 1972 Proposals Described by Reviewers as Using
Population as a major focal point of study (Environmental Education
Act)

1. Baltimore City Public Schools *	\$11,395
Baltimore, Maryland 21218	
(Mr. Forest L. Lawton)	
2. State Univ. College at Buffalo*	12,300
Buffalo, New York 14222	
(Dr. John B. Morganit)	
3. Ohio Environmental Council	9,955
Cincinnati, Ohio 45236	
(Judith M. Schultz)	
4. Planned Parenthood	36,720
Burlington, Vermont 05401	
(David Wagner)	
5. Norfolk Cty TB&RD Ass'n	1,945
Westwood, Massachusetts 02090	
(Frances H. Pitts)	
6. ZPG Fund	9,550
San Francisco, California 94111	
(Mark Horlings)	
7. Indiana University *	35,000
Bloomington, Indiana 47401	
(Jerry L. Brown)	
8. Children's Museum Hfd.	64,382
West Hartford, Connecticut 06119	
(Harry H. Ryder)	
9. Charlotte Nature Museum	68,234
Charlotte, North Carolina 28209	
(Russel I Peithman)	
10. Liberty School, Bd of Educ.	35,175
Englewood, New Jersey 07631	
(Michael A. McGlue)	

'72 Pop Ed Proposals Received -- Page 2

11.	Raymond Walters College (U of Cinn)* Cincinnati, Ohio 45236 (Judith Schultz)	\$ 5,000
12.	Genesee Valley Environmental Assoc. Geneseo, New York 14454 (Zolmon Benir)	7,634
13.	Population Institute Washington, D.C. 20002 (Rodney Shaw)	30,935
14.	F-M Chapter of Z.P.G.* Fargo, North Dakota 58102 (David E. Walsh)	4,000
15.	Planned Parenthood New Haven, Connecticut 06511 (Jack H. Smith)	26,079
16.	Planned Parenthood New Haven, Connecticut 06511 (Jack H. Smith)	25,000
17.	"	19,250
18.	"	16,925
19.	Delaware Dept of Public Instruction Dover, Delaware (Dr. Randall L. Broyles)	36,000
20.	Emory University Atlanta, Georgia 30322 (Dr. Charles T. Lester)	151,835
21.	Norfolk Cty TB&RD Ass'n Westwood, Massachusetts 02090 (Frances H. Pitts)	11,320
22.	AAUW- Salisbury Branch Salisbury, North Carolina (Edith Alcorn)	4,670

FY 72 Pop Ed Proposals -- Page 3

23. Univ of North Carolina (Education) *	20,000
Chapel Hill, North Carolina 27514	
(Art Hurow)	
24. Pacific NW Environmental Educ Institute	18,270
Seattle, Washington 98103	
(Roger Hagan)	
25. The City College	10,000
New York, New York 10031	
(Harold J. McKenna)	
26. College of Arts and Science	9,527
Geneseo, New York 14454	
(Dr. Phyllis T. Thompson)	
27. ZPG Fund	16,850
San Francisco, California 94111	
(Mark Horlings)	
28. Fort Worth Ind. School District	130,932
Fort Worth, Texas 76107	
(Theodore C. Hofsiss)	
29. Multnomah Cty Inter Educ District	18,103
Portland, Oregon 97216	
(Richard E. McQueen)	
30. Florida Tech University	15,802
Orlando, Florida 32816	
(Phillip K. Taylor)	
31. ZPG Fund	170,710
San Francisco, California 94111	
(Mark Horlings)	
32. L.A. Community Schools	9,900
Los Angeles, California 90051	
(Martha Lightner)	

* Funded

Senator CRANSTON. I know there has been some confusion about the fiscal 1973 appropriation for environmental education because of technical problems with the processing of OE grants and contracts last summer. Can you tell us how much money will be available for grants under your office this year?

Mr. BOGAN. \$1.1 million, which has been obligated. We will be able to submit a list of those for the record, and we have broken out those that address population specifically and those that have population education components.

Senator CRANSTON. What proportion of the available funds will be for population-related projects?

Mr. BOGAN. I think the answer to this question will shed some light on the previous one. In this current grant competition we have received population education proposals. Of 28 received, 12 projects specifically addressing population education were funded, eight of which have a substantial population education component.

Senator CRANSTON. What proportion of projects will contain population components?

Mr. BOGAN. Of the 49 funded, 12 of them have an identifiable population component, or roughly a quarter.

Senator CRANSTON. That will be described in that list, I presume.

Mr. BOGAN. Yes.

[The information subsequently supplied follows:]

**FY 1973 Environmental Education Act Projects
which Include Population Education**

<u>Project</u>	<u>Description</u>	<u>Amount</u>
CONNECTICUT		
Lawrence M. Shaeffer E-P Education Services, Inc. 625 Orange St. #38 New Haven, Ct 06511	Environment-Population Education Services, Inc., will design an environmental problems course for high school	\$6,110
Tel: 203-787-1851		
DELAWARE		
Arnold L. Lippert University of Delaware College of Education' Hall Building Newark, De 19711	Current population-environment studies will be integrated into existing school programs. The project will be carried out with the support of the Univ. of Delaware, Delaware State College, the Department of Public Instruction, the Department of Natural Resources, and the Delaware Conservation Association, as well as local business, industry, and various service organizations.	\$38,914
Tel: 302-738-2147		
FLORIDA		
Robert M. Johnson Social Studies Education Florida State University Tallahassee, FL 32301	The project will produce episodic materials for use in teaching American history to eighth graders. Eight different periods of American history will be discussed, and the changes in the North American environment during these periods will be stressed, with special emphasis on population factors	\$21,535
Tel: 904-599-3860		

Page 2

WASHINGTON

Mike Ruby
Zero Population Growth-
Seattle Chapter
4426 Burke Avenue N.
Seattle, Washington 98103

Tel: 206-583-2070

The Seattle Chapter of Zero Population Growth will hold a series of workshops on population growth and its relationship to the environment and environmental problems

\$ 7,515

Projects with Population Education Components

ARKANSAS

A.W. Ford
Arkansas Department of
Education
Instruction Division
Arch Ford Building
Capitol Mall
Little Rock, Ark 72201

Tel: 501 371-2061

The Arkansas State Dept. of Education will take the best environmental education/studies materials developed for the junior and senior high schools and will modify these for use in Arkansas. The project will be carried out by means of a series of workshops and by providing technical assistance to participating schools. Population education materials developed in FY 72 will be modified and disseminated.

\$38,317

CALIFORNIA

Max K. Linn
John Muir Institute for
Environmental Studies
2118 C Vine Street
Berkeley, CA 94709

Tel: 415 956-4940

The John Muir Institute will develop, test, and evaluate self-instructional environmental education materials for urban junior and senior high school students. The materials will foster the acquisition of problem-solving skills and ecological-environmental concepts. Population studies will be included in the materials.

\$25,000

Page 3

DISTRICT OF COLUMBIA

Arthur A. Davis
The Conservation Foundation
1717 Massachusetts Ave, NW
Washington, D.C. 20036

Tel: 202 265-8882

The Conservation Foundation with the assistance of the Ohio State University School of Natural Resources will develop five case studies, each in a different format on major local environmental issues which are also of national concern for use in secondary schools' environmental studies. Population impact will also be considered in developing these case studies. \$35,000

INDIANA

John W. Ryan
Indiana University Fdn
School of Public and
Environmental Affairs
P.O. Box F
Bloomington, Ind. 47401

Tel: 812 337-7237

The School of Public and Environmental Affairs of Indiana University will research, develop, edit, and publish a collection of case studies on environmental issues for use at the junior and senior high school level. Population issues will figure in the case studies.

\$40,000

MICHIGAN

John D. Yolton
International Union
United Automobile, Aero-
Space, and Agri-Implement
Workers of America - UAW
Department of Conservation
and Resource Development
8000 E. Jefferson
Detroit, Mich. 48214

Tel: 313 926-5271

The United Auto Workers will introduce an environmental education training course for its local leadership and their families. The course will be based on existing materials, and will focus on community environmental problems. Population impacts on urban areas will be considered.

\$24,771

Page 4

MISSOURI

Penelope H. Royse
Committee for Environmental
Information
438 North Skinker Boulevard
St. Louis, Missouri 63130
Tel: 314-863-6560

The Committee for Environmental Information will produce, test, and evaluate curriculum units on environmental problems for use in local high schools. The units will be based on material appearing in Environment Magazine. Population issues are discussed in this series.

\$22,500

FLORIDA

R.F. Mines
National Association
for Environmental Education
P.O. Box 1295
5940 S.W. 73 Street
South Miami, Florida 33143
Tel: 305-274-1381

The National Association for Environmental Education, with the assistance of the nation's leading elementary-level environmental education teachers and curriculum specialists, will develop a model curriculum in environmental studies in modular form for grades four through eight. A modular unit on population studies will be developed.

\$28,200

OHIO

Joseph H. Chadbourne, Jr.
Institute for Environmental
Education
8911 Euclid Avenue
Cleveland, Ohio 44106
Tel: 216-231-5010 X 57

The Institute for Environmental Education will facilitate the expansion of the Cuyahoga Watershed Project into Cuyahoga Heritage by expanding the project locally and disseminating the model nationally through other watershed and heritage groups. A curriculum activities guide to population and environmental studies will be developed.

\$64,000

Senator CRANSTON. I have some further questions that I will submit for the record since we are running out of time.

Back to you, Dr. Hellman, what has your office been doing to encourage population components in the projects supported by the Office of Environmental Education? What authority do you have?

Dr. HELLMAN. The authority I have derives from the original Family Planning Services and Population Research Act that specifies that we make available family planning and population information and that we oversee the other activities for which the Secretary is responsible related to population and family planning. We have worked closely with the Office of Education on several projects, the most noteworthy of which was the filmed report of the Commission on Population Growth and the American Future.

Senator CRANSTON. I am talking about your specific activities re the Office of Environmental Education.

Dr. HELLMAN. I would say that this was our major activity for last year, Senator.

Senator CRANSTON. One final question. I would like to return to your role in stimulating population education activity within the department. A year and a half ago you told us you had no population education staff and you hoped to get somebody. Since that time have you been able to add anyone to your staff?

Dr. HELLMAN. I have. Ms. Galaid is on my staff fulltime.

Senator CRANSTON. If you would submit biographical data on her, I would appreciate it.

Dr. HELLMAN. See item III A4 on page 367.

Senator CRANSTON. I also have some questions on social science research which I will submit for the record.

That concludes the questions that will be verbal. I thank you very much for your presence and your efforts to respond.

I thank the others present for their interest.

I want to say that we have been informed that a group of doctors and nurses based in New York wish to submit a statement for the record. We will be delighted to place this statement in the record.

These hearings are now adjourned, and the hearing record will close on June 4.

Thank you all very much. We stand adjourned.

[Thereupon, at 12:30 p.m. the hearings were adjourned.]

[The following information was subsequently supplied for the record:]

Additional Questions Requested by the Committee

I. Population Research

- A. In your prepared testimony, on page 16, you state that "population research activities will be continued under Title III of the Public Health Service Act." Is this Section 304 which authorizes research and demonstrations in health services? If so, what authority are you proposing to use for the basic and applied research in human reproduction and contraceptive development?

Population research activities will be continued under Section 301 of the PHS Act which authorizes the conduct and support of research, investigations, experiments, demonstrations, and studies.

- B. Would you outline for us a general strategy for the conduct of population sciences research...That is, what would be the program elements of a strong population sciences research program in order to accomplish advances in this field?

The program elements of a strong population sciences research program are outlined in the population research section of the second progress report.

- C. The Administration has been opposed to separate authorities for research, except that recently it strongly supported separate authorities for the National Cancer Institute and for the National Heart and Lung Institute. In all other cases, it has stated that NIH's general authority would be sufficient. Would you please tell us your objections to a separate authority for population sciences research?

The Administration believes that it is in the best interest of both the Congress and the Administration to consolidate legislative authorities whenever this can be done without adversely affecting operations.

- D. What would be some of the advantages of a separate authority for this research? Wouldn't give the program more visibility and accountability and be able to attract high calibre researchers into the field?

The Administration believes that any advantages of separate authorities for each category of research are outweighed by unnecessary proliferation of such categorical authorities.

II. Social Science Research

- A. Dr. Simmons, in your testimony you indicate that "we are also concerned that removing research on biomedical and behavioral aspects of population from the National Institute of Health would be detrimental..." because "our experience in biomedical research has shown that there are numerous interconnections among subfields..." Could you explain how the loss of interconnections with biomedical subfields would be detrimental to the behavioral research program of The Center for Population Research?

Biomedical and behavioral population research have perhaps their most important connections and interrelationships in the areas of fertility and family planning.

In performing research on fertility, major problems arise in attempting to discover the determinants of fertility. Generally speaking, both theory and findings concerning these determinants point to multiple antecedents including biological, medical, health, social, psychological, economic, educational, political, cultural, and other factors. The relative contribution of the various factors and the manner of interaction among them constitutes a very important area of research in which the interrelationships of the biomedical and behavioral factors have received relatively little study. Such studies should increase basic understanding of the determinants of fertility which would have scientific significance and also assist in the development of family planning programs and population policies.

Biomedical and behavioral research are interrelated to a great extent in the study of fertility regulating methods, including contraceptive techniques, abortion, and sterilization. Biomedical research is basic to the development of many fertility regulation methods, such as pills, IUD's, injections, and sterilization. However, the choice, use-effectiveness, acceptability, effects, and continued use of these methods involves biomedical, social, psychological, economic, cultural and other factors. Therefore, an approach involving biomedical and behavioral research is necessary to understanding and furthering the development, utilization and effectiveness of fertility regulating methods. It should be emphasized that these methods are basic to family planning programs. Likewise, the family planning programs themselves need to be developed and evaluated by biomedical and behavioral specialists.

Another area of population research in which biomedical and behavioral investigations interrelate is the interaction of endocrinological and behavioral factors in sexual behavior. Since the nature and amount of sexual behavior is related to fertility, this is important to the population field.

- B. Dr. Hellman, on the Secretary's Advisory Council on Population Research there are a number of distinguished researchers in population dynamics. Have they expressed this opinion to you or made any recommendations on how research in population dynamics could best be administered?

The Secretary's Advisory Council has not made any specific recommendations on how research in population dynamics could best be administered.

- C. Dr. Simmons, in previous appearances and budget justifications H.E.W. has taken the position that a more rapid increase in population research, in particular the social science program, was not possible in the absence of a greater capacity by the field to absorb more money. A statement submitted to the Committee by Dr. John Kantnor indicates that while the total number of social science projects approved by N.I.C.H.D. increased by 32%, the number of projects funded decreased by 12%. In light of this, is it still the Department's position that it is spending all the money in the social science field which that field can absorb?

Sufficient resources are currently available to fund all promising social science projects.

- D. Dr. Hellman, how many projects is The Center for Population Research funding which are directly aimed at discovering the causes and implications of the recent declines in fertility?

1. U. S. Bureau of the Census (reimbursable agreement), "Relationship between age at marriage, birth intervals and total fertility," \$140,000 (FY 1971); \$165,000 (FY 1972).

This project has enabled the Census Bureau to add certain questions to the Current Population Surveys of June, 1971, 1972 and 1973. The information obtained from these questions will make it possible to estimate the extent to which the recent decline in fertility is due to the delay of births that will occur eventually and the extent to which it is due to a decline in completed fertility by the end of the childbearing period of life.

2. Princeton University, "National Fertility Survey, 1970" \$222,000 (FY 1970), \$519,000 (FY 1971), \$391,000 (FY 1972).

This study is providing information on changes in the number of children desired, changes in the methods of fertility control, and the effects of these changes on fertility. A major finding of the study is that unwanted pregnancies declined by 36 percent during the 1960's.

3. Center for Family Planning Program Development, "Development of methodology for evaluating the demographic impact of organized family planning programs in the United States," \$112,000 (FY 1973).

The major purpose of this project is to estimate the impact of subsidized family planning services on fertility in the late 1960s.

In FY 1974, the Center plans to request proposals that will help to identify more clearly the factors responsible for the rise and decline in fertility during the period 1940-1970.

In addition, the Center supports a number of other studies which will help to clarify the causes of the recent decline in fertility. Many of these studies deal with the changing roles of American women, including their increased participation in the labor force and their efforts to improve their occupational status.

The Center also supports several studies on the effects of childbearing patterns which will be helpful in evaluating the impact of the current decline in fertility on the American family. In addition, the Center has requested and is currently reviewing proposals for projects dealing with the economic and environmental consequences of various rates of population growth in the United States.

- E. Dr. Hellman, the Center recently issued a request for proposals to explore the consequences of population growth for our society, and indicated that it hoped to fund "two or three" such proposals next year. Do you think this represents an adequate federal effort to understand changes in our fertility patterns that might mean projections may be off as much as 25%?

The two or three studies on "Economic and Environmental Consequences of Population Growth" which the Center expects to fund do not represent an adequate federal effort to understand all the implications of varying rates of population growth in the United States.

However, the Center's anticipation of only two or three studies was based on its assessment of the readiness among competent researchers to undertake studies of the scope outlined in the RFP. The issues relating to the environmental and economic consequences of population growth are complex, and exploring the interrelationships among them is exceedingly challenging. Work in this area requires expertise in several disciplines. On the basis of its awareness of the "state of the art", the CPR Staff felt it would be fortunate to receive two or three scientifically sound studies in response to the RFP.

Of the proposals received, the scientific review panels found four acceptable, deferred action on one pending receipt of additional information, and recommended that three be revised and resubmitted. If the four acceptable proposals are approved, CPR has the \$700,000 required to fund them.

Study of the consequences of population growth is part of CPR's ongoing research program, and additional research in this area will be solicited.

III. Population Education

A. General HEW Support

1. What are the major activities of your office in the population education area?

The Office of Population Affairs promotes support and understanding of population education and information among HEW and Federal agency information staffs, media representatives, civic, educational, and social and religious groups. The Office coordinates population education efforts within the Department. The Office also coordinates population education program policies with program officers of HEW to insure consistency.

2. A year and a half ago you told us that you were chairing an Ad Hoc Committee on Population Education in HEW. What were the conclusions of that committee? Were they adopted as official HEW policy?

The following recommendations of the Ad Hoc Coordinating Committee on Population Education were approved by HEW Secretary Elliot Richardson on January 16, 1972, and subsequently adopted as official HEW policy:

- a. That the Secretary, on the appropriate occasion, communicate departmental support for population education.
 - b. That the Secretary designate the Office of Population Affairs as the lead agency for population education within the Department (recognizing that the Commissioner of Education has already designated the Office of Environmental Education as the lead agency for population education within the Office of Education).
 - c. That there be established within the Office of Population Affairs a unit for population education to encourage and coordinate the development of an adequate population education effort by the Department. The unit would also provide liaison with other Federal agencies and with appropriate private groups and organizations.
3. What positive steps have you taken to encourage the introduction of population education activity into other departmental programs, as I understand the Ad Hoc Committee recommended that you do?

The Office of Population Affairs meets regularly with the information, education, and research staffs of the Office of Environmental Education, Office of Education; the National Center for Family Planning Services, Health Services and Mental Health Administration; and the Center for Population Research, National Institutes of

Health in a continuing effort to establish plans, objectives and programs in the area of population education.

4. Have there been any new organizational arrangements in your office or elsewhere made to strengthen the coordination of these programs, pursuant to the report of this Ad Hoc Committee?

The Office of Population Affairs has hired a Special Assistant for Information and Education.

Biographical Sketch

Name: Ruth C. Galaid

Position: Special Assistant for Information and Education, Office of Population Affairs

Birthplace and date: New York, New York, November 5, 1925

Education: University of California, Berkeley, graduated 1948, B.A.

Experience: Present--Special Assistant for Information and Education, Office of Population Affairs, HEW; 1968-72, Editor, Grants Administration Report, HEW; 1965-68, Editor, Welfare in Review, HEW; 1964, Writer, National Geographic Magazine; 1962-63 Consultant-writer, Ford Foundation, Cairo and Buenos Aires; 1961-62, Reporter-researcher, Time Inc.; 1958-60, Account Executive, S.H. Benson, Ltd., Nairobi, Kenya; 1956-58, Reporter-researcher, Time Inc.; 1955-56, Reporter, Burlingame Advance-Star, Burlingame, California; 1953-55, Administrative Assistant, Ford Foundation, New Delhi, India; 1952-53, Research Assistant, Ford Foundation, New York; 1950-52, Program Director, U.S. Army, Stuttgart, Germany; 1949-50, Secretary-Research Assistant, University of California, Berkeley; 1942-45, Secretary, New York Times.

Awards and honors: Sustained Superior Work Performance Award, 1967, HEW; Certificate of Appreciation, The President's Economic Stabilization Program, 1971; Who's Who of American Women, 8th Edition.

5. Do you feel that the American people are adequately informed about the meaning and implications of the dramatic demographic changes of the past two years?
 - a. If your reply is yes, does your office have any studies or evidence showing the extent and nature of public understanding of these phenomena? Could you supply them for the record?
 - b. If your reply is no, what kind of role do you think your office could play in improving public understanding of these kinds of events?

In a grant program addressing a new and difficult educational development area, some projects will be less successful than others. However, significant gains are being made in conceptualizing and demonstrating effective approaches to the broad range of subjects and issues encompassed by the Environmental Education Act's definition of environmental education.

2. I understand that the Advisory Council on the Environmental Education Act has submitted a report and made several recommendations, among them a recommendation to extend that Act. Has any action been taken on this report by the Office of Education or has any response been made to the recommendations of the Commission?

Advisory Council members discussed their report and its recommendations with the Commissioner of Education at the time of its submission. No action can be taken on those recommendations at this time due to the fact that the Environmental Education program is scheduled to be phased out at the end of the current fiscal year.

- a. Newspaper accounts and public opinion polls indicate that the American public is becoming aware of the recent decline in fertility. However, Americans may not recognize or understand the long-range implications of population change.
- 6. Do you think the funding levels provided in S. 1708 would be adequate to enable your office to carry out an effective role in this area?

If your reply is no, what funding levels would you personally suggest?

The current funding level is considered adequate for population education activities.

- 7. Do existing institutions or units of local government have resources to contribute measurably to the job that is needed?
- 8. What has their record been in the past?

7, 8. Since the Office of Population Affairs does not collect specific information on the resources and capabilities of non-Federal agencies and organizations, it is unable to supply this data.

- 9. The surveys the Population Commission did indicate strongly that the American people are not adequately educated on population dynamics. Witnesses before these hearings have expressed their belief that this is still true. Does your office have new evidence to show a change in that situation?

The Office of Population Affairs does not know of any survey of the American public's awareness of population issues conducted since the Commission's surveys.

- 10. Can you cite specific examples of this; are there school systems around the country which have been able to do an adequate job in this area?

The Office of Population Affairs has no information in this area.

B. Office of Education Programs

- 1. A survey of environmental education grantees, conducted by Friends of the Earth, found that in both fiscal years 71 and 72, grantees not only devoted less than 10% of their efforts to population, but also that they devoted more than 25% of their efforts to subjects not even covered in the legislative definition of environmental education. Can you explain this apparent deviation from the Congressional intent?

APPENDIX

HARRISON A. WILLIAMS, JR., N.J., CHAIRMAN
 JENNINGS RANDOLPH, W. VA.
 CLAIBORNE PELL, R.I.
 EDWARD M. KENNEDY, MASS.
 GAYLORD NELSON, WIS.
 WALTER F. MONDALE, MINN.
 THOMAS F. EAGLETON, MO.
 ALAN CRANSTON, CALIF.
 HAROLD E. HUGHES, IOWA
 WILLIAM D. HATHAWAY, MAINE
 JACOB K. JAVITS, N.Y.
 PETER H. DOMINICK, COLO.
 RICHARD S. SCHWEIKER, PA.
 ROBERT TAFT, JR., OHIO
 J. GLENN BEALL, JR., MD.
 ROBERT T. STAFFORD, VT.
 STEWART E. MCCLURE, STAFF DIRECTOR
 ROBERT E. MAGLE, GENERAL COUNSEL

United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

May 29, 1973

Dr. Louis Hallman
 c/o Dr. John Zapp
 Deputy Assistant Secretary
 for Legislation
 Room 5448/NEW North Building
 Washington, D.C. 20201

Dear Dr. Hallman:

Dr. Ada Riffar Ryan, President of the Committee of Doctors and Nurses Vs. Abortion, submitted the enclosed testimony to the Committee for inclusion in the hearing record.

On pages 4 and 5 of her testimony, she describes a saliva test which was developed several years ago, which she states determines the rise in alkaline phosphatase in the blood occurring at the time of ovulation. She states, "It has deliberately been kept off the market in the U.S. although it has been used overseas." Dr. Ryan goes on to say, "The introduction of this test to the public would automatically eliminate the hazardous contraceptives that are being fostered by Planned Parenthood." Dr. Ryan asked that the Committee and the Department of Health, Education and Welfare investigate this test and prepare a report on the results of such an investigation.

I would appreciate your providing the Subcommittee with a report on the effectiveness of this procedure.

With many thanks.

Sincerely,

Alan Cranston
 Chairman, Special Subcommittee on
 Human Resources

Enclosure

COPY



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20501

June 12, 1973

Honorable Alan Cranston
Chairman
Special Subcommittee on Human Resources
Committee on Labor and Public Welfare
Washington, D.C. 20510

Dear Senator Cranston:

Thank you for your letter of May 31 and the enclosed testimony of Dr. Ada Biffar Ryan concerning a test for saliva alkaline phosphatase as an indicator of ovulation.

The saliva test was developed at the Western Laboratory which is a subsidiary of the General Tire Company. The test may have been originated by a Chicago obstetrician, but it was first publicized by a Mr. or Dr. Foster in a presentation before the American Chemical Society in September 1971. There was a subsequent publication in the Journal of the American Chemical Society and some publicity in Newsweek Magazine. Shortly thereafter there were a few haphazard clinical trials. As far as I can gather, these proved rather unsatisfactory in that a number of post-menopausal women and dogs and Dr. Sheldon Segal of the Population Council proved to have positive tests.

The President of the General Tire Company asked Dr. Andre Hellegers to act as consultant. In reviewing the evidence, Hellegers found no substantial proof that this test gave an accuracy of more than 30 per cent for the time of ovulation. The President of General Tire Company offered it to Dr. Hellegers for further testing at the Georgetown Center of the Kennedy Foundation and indicated that he had spent over a million dollars in development. Dr. Hellegers

Page 2 - Honorable Alan Cranston

thought so little of the test that he declined the offer. The Western Laboratory has since gone bankrupt.

Obviously, if the test were of any value, it would have required FDA regulation because the tapes which are put in the mouth to perform the test, contained certain chemicals, thus, are regarded as drugs.

I believe Dr. Ryan is incorrect in her statements regarding the reports of the New York Health Department. These have always been available for public information and I now have on my desk a rather voluminous report of the first two years' experience with the New York Abortion Law which will be published in a forthcoming book. Should your Subcommittee desire full documentation of the New York experience I would be glad to make this information available.

I will be glad to furnish any additional information your Subcommittee may desire.

Sincerely yours,



Louis M. Hellman, M.D.
Deputy Assistant Secretary
for Population Affairs

HARRISON A. WILLIAMS, JR., N.J., CHAIRMAN
 JEROMES RANDOLPH, W. VA.
 CLAIRBORNE PELL, R.I.
 EDWARD M. KENNEDY, MASS.
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 WILLIAM D. HATHAWAY, MAINE

JACOB K. JAVITS, N.Y.
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 ROBERT T. STAFFORD, VT.

STEWART E. MCCLURE, STAFF DIRECTOR
 ROBERT E. HABLE, GENERAL COUNSEL

United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

June 13, 1973

Louis M. Hellman, M.D.
 Deputy Assistant Secretary for
 Population Affairs
 Department of Health, Education and Welfare
 North Building
 Room 4069
 330 Independence Avenue, S.W.
 Washington, D.C. 20201

Dear Doctor Hellman:

The attached letter from Mr. John Short, published
 of Triumph, raises several questions relevant
 to the Subcommittee's consideration of legislation
 to extend the Family Planning Services and Population
 Act of 1970.

I would appreciate your responding to the several
 questions he raises.

With many thanks,

Sincerely,

Alan Cranston

Enclosure

COPY

Triumph

A PUBLICATION OF
THE SOCIETY FOR THE CHRISTIAN COMMONWEALTH

278 Broadview Avenue | (703) 347-4700
Warrenton, Va. 22186 | Cable: TRIMAG

May 24, 1973

Senator Alan Cranston, Chairman
Subcommittee—Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

I wish to thank you for exploring my question with Dr. Hellman of the Department of Health, Education and Welfare, as to whether or not the intra-uterine device is an abortifacient. His answer, however, you must admit, leaves a lot to be desired and will have to be more direct.

When you questioned him and the other representatives of the Department of Health, Education and Welfare concerning eligibility requirements it was stated that statutory requirements specifically limit methods to the time before pregnancy and, devices, procedures, or the like would not be included in the program if they terminated pregnancy. Now, then, do either you or Dr. Hellman justify the inclusion of the IUD in the program, particularly after he, as an administrator and a "man of science," said he was not sure that it met the eligibility requirements? Could I please have a simple "yes" or "no" answer to the following question: Does or does not the device, procedure, or the like have to meet the eligibility requirements before it is included in the program?

A most disturbing aspect of the hearing was the testimony given concerning that question. As you were asking your question and Dr. Hellman was giving his answer both of your aides had in their possession a copy of the current 5-Year Plan for Population Research and Family Planning Services prefaced by a letter from Caspar Weinberg, Secretary of Health, Education and Welfare, dated May 17, 1973. Since, as you will recall, I was sitting directly opposite Dr. Hellman's aide I had no trouble in reading page 15 of that report concerning the IUD, which reads as follows:

"Recent study results support the hypothesis that the IUD alters the uterine environment in such a manner that blastocysts are destroyed or are not able to stay in the uterus until an estrogen surge permits implantation (Chang). If the IUD is removed before day 4 of pregnancy, there is an improved likelihood of survival of the fertilized ovum."

As you will note two types of results are reported: (1) the abortifacient character of the IUD and (2) the exact time period, or more precisely, almost the exact day of pregnancy abortion is to occur, which confirmed the results in the findings published by Dr. Thomas Hilgers of The Mayo Clinic, Rochester, Minnesota.

Again I ask, keeping in mind the above results, will you give me a simple "yes" or "no" answer to the question: Does the IUD meet the eligibility requirements of the program?

- 2 -

A second point was raised by you and Dr. Hellman concerning the IUD program as it relates to our involvement through A.I.D. in distributing and fostering these devices overseas. Similar to the question you asked of the administration concerning the involvement of drug companies domestically, who holds the patent on the IUD being provided by this country for heavy overseas use?

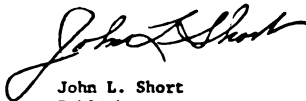
Although I was not able to read everything in the 5-Year report Dr. Hellman's aide had in front of him I did notice repeated references to the FDA concerning testing of various procedures and the like. The question I ask is the same as that raised by Dr. Ryan: "What do the FDA records reveal concerning the "Alkaline phosphates level test" or, as it was commonly referred to, "the saliva test" and what are future plans concerning this test?

I was also interested in the testimony concerning voluntarism and the line taken by you concerning state regulations. Could I also have a simple "yes" or "no" answer to the question on whether or not welfare recipients or persons somehow classified as low income may or may not be called in at least twice a year and questioned concerning their practice or marital relations and intentions toward procreation and attitudes toward family life? Could you also advise me as to what may be the current policy as well?

Since I have not yet received the legal opinion you promised, I was quite disappointed that you did not raise the question concerning the right of privacy particularly as it relates to the recent Supreme Court decision which held that there is, prior to a new life coming into existence, tantamount to an absolute right, a right of privacy which prevails in the areas of marital relations, intentions toward procreation and attitudes toward family life, and the government is prohibited from legislating or inquiring in this area, let alone mandating, except for the gravest of reasons such as legislation protecting the rights and responsibilities of parents. Could I please have your opinion, and the administration's opinion, concerning this right of privacy and how it will be affected by legislation proposed by each of you. From the presentations made by yourself and the administration I could only conclude that both of your goals appear to be the same but that you differ as to the administration of the programs designed to implement this common goal. Since your goal is the same I feel a common question concerning how it effects the right of privacy is in order.

I thank you for advising us that the record will be kept open until June 4 and I would appreciate a reply prior to then as I would like this request, your reply and my response to your reply entered into the record and, if necessary, I will hand deliver my response to your office on June 4 so that this may be accomplished.

Sincerely yours,



John L. Short
Publisher



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20001

June 29, 1973

Honorable Alan Cranston
Chairman
Special Subcommittee on Human Resources
Committee on Labor and Public Welfare
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

Thank you for your letter of June 13 containing the enclosure and questions from Mr. John Short, publisher of Triumph.

The paragraph quoted by Mr. Short from the Second Annual Progress Report of the Five-Year Plan for Family Planning Services and Population Research, p. 15, is from the research work on rats by Dr. Chang of the Population Council. The mechanism of action of the IUD differs with the species of experimental animals employed. The results with experimental animals cannot be transposed to human beings.

Dr. Hilgers' paper is a review of the literature. It was presented to part of the staff at the Mayo Clinic in 1972, and as far as I am aware, the article has not been published in a scientific journal. The conclusions are Dr. Hilgers' and do not represent scientific proof nor a consensus among scientists.

My statement on the IUD's in the typed transcript of our testimony before your Subcommittee on May 22 is clear and concise. The mechanism of action of the IUD (in the human being) is unknown. This statement does not represent only my opinion. It was made after consultation with the following and thorough review of the literature.

Dr. Sheldon J. Segal
Vice President
The Population Council

Page 2 - Honorable Alan Cranston

Dr. Luigi Mastroianni
Chairman, Department of
Obstetrics and Gynecology
University of Pennsylvania
Medical School

Andre Hellegers, M.D.
Professor, Department of
Obstetrics and Gynecology
Georgetown University

I assume Mr. Short is aware that HEW has no responsibility and cannot speak for A.I.D. Attached for your information is a copy of Dr. R. T. Ravenholt's statement on Abortion Aspects of U.S. Population Assistance Programs.

On June 12 I wrote to you concerning Dr. Ryan's assertions about the "tape tests" for ovulation. I have some additional information as follows:

On May 8, 1967 two INDs were submitted by Weston Laboratories for use in oral diagnosis of ovulation. Following the original submission no data were received until April 1970, at which time two volumes were submitted. Not only did the sponsors own data indicate an accuracy of less than 50 percent, but at a conference with FDA on June 16, 1970, Mr. R. O. Foster and Dr. A. B. Lorincz, monitors for the trials for Weston Laboratories, admitted that they knew their data to be inaccurate and incomplete. The sponsor was given 10 days to repair the deficiencies. No reply was received within the specified time and the IND was withdrawn.

There are continuing surveys regarding knowledge, attitudes and practices in the area of family planning. These are conducted privately, by the State and local health departments, and by several agencies of HEW. Inasmuch as Mr. Short asks a general and not a specific question directed at a particular survey, I can only respond concerning our general guidelines for these studies.

Page 3 - Honorable Alan Cranston

1. Surveys are not conducted on family planning patients without approval by the proper authorities.
2. HEW support for a survey requires a review and approval of the objectives and benefits to be derived and all questions are reviewed by the agency contract officer, officials of HEW outside my office, and by OMB.
3. No patient may be questioned without his/her informed consent.
4. Each patient must be informed of his/her right of refusal to enter the study.

The Social and Rehabilitation Service has not yet furnished us the guidelines for welfare clients. As soon as they are received I will forward them to you.

The legal questions regarding the right of privacy posed by Mr. Short are not clear to me. I fail to see how either P.L. 91-572 or your currently proposed legislation violates the right of privacy, particularly when they have so scrupulously emphasized voluntarism. If Mr. Short wishes I can arrange a meeting with our General Counsel to clarify the issue.

Please be assured of my continuing cooperation.

Sincerely yours,



Louis M. Hellman, M.D.
Deputy Assistant Secretary
for Population Affairs

Enclosure

EXECUTIVE BRANCH COMMENTS**Zablocki Concern with Abortion Aspects of U.S. Population
Assistance Programs**

In providing assistance for population and family planning in developing countries, the U.S. seeks to enlarge the freedom of these sovereign countries and individuals to choose the reproductive patterns most conducive to their well-being; and just as it would be grossly inappropriate for the U.S. to coerce these countries and individuals to use fertility control means which they do not want, so it would also be grossly inappropriate for the U.S. to coerce these sovereign countries and individuals to not use fertility control means which they do wish to use. Surely, such reverse coercion would have a powerful negative impact upon the concept and practice of international population program assistance, and would cancel much of the effectiveness of A.I.D.'s voluntary approach to population programs.

June 15, 1973

NICHED
FY 1973
POPULATION PROGRAM RESEARCH GRANTS
APPROVED BUT UNFUNDED

<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
446-13A1	\$ 22,163	SPAZIANI, Eugene	University of Iowa
472-17	30,835	SWEAT, Max L.	University of Utah
488-14A1	30,000	FREUND, Matthew J.	New York Medical College
893-11	46,311	WHALEN, Richard E.	University of California, Irvine
1182-11S1	9,800	GORSKI, Roger A.	University of California, Los Angeles
1199-15S1	8,500	TOUCHSTONE, Joseph C.	University of Pennsylvania
1199-16	53,248	TOUCHSTONE, Joseph C.	University of Pennsylvania
2615-06	42,203	LISK, Robert D.	Princeton University
3071-06	60,000	BRINSTER, Ralph L.	University of Pennsylvania
3084-04A1	15,740	SARTO, Gloria E.	University of Wisconsin
3097-05A1	26,580	JOHNSON, Donald C.	University of Kansas Medical Center
3266-06	55,000	NELSON, Leonard	Medical College of Ohio
3471-10A1	24,880	FOOTE, Robert H.	Cornell University
3577-05	73,040	GLEDHILL, Barton L.	University of Pennsylvania
3822-04	166,875	VANDEMARK, Noland L.	Ohio State University
4020-04	30,290	SHIVERS, Charles Alex	University of Tennessee
4104-03	19,121	BECKETT, Sidney D.	Auburn University
4108-04	30,514	MEYERSON, Bengt J.	Uppsala University
4189-05	18,356	HOWE, George R.	University of Massachusetts
4290-04	46,635	HAMILTON, David W.	Harvard Medical School
4375-04A1	27,123	PIACSEK, Bela E.	Marquette University

<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
4471-04	\$ 36,725	ELY, Charles A.	Columbia University
4484-04	15,000	BARFIELD, Ronald J.	Rutgers University
4484-04A1	18,857	BARFIELD, Ronald J.	Rutgers University
4543-04	31,544	MILLER, Richard L.	Temple University
4671-04	25,028	MALACINSKI, George M.	Indiana University
4702-04	61,026	ROSENBERG, Murray D.	University of Minnesota
4714-04	25,325	SCHLAFF, Sheldon	Jefferson Medical College
4738-03A1	20,000	MORTON, Bruce E.	University of Hawaii
4787-04	29,051	TERMAN, C. Richard	College of William and Mary
5040-03	13,208	WISHIKAWARA, Margaret T.	Ohio State University
5101-03	25,120	PARR, Earl L.	Harvard Medical School
5259-02B1	12,296	ERICKSON, Robert P.	University of California San Francisco
5413-01A1	30,240	ANDERSON, Gerald G.	Yale University School of Medicine
5656-01A1	25,725	JUNGMAHN, Richard A.	Northwestern University
5723-01A1	28,765	KIM, Kwang S.	George Washington University
5729-01A1	30,000	PETERSON, Rudolph M.	New York Medical College
5798-01A1	253,643	FREYMAN, Moye W.	University of North Carolina
5846-02B1	26,474	LONGO, Frank J.	University of Tennessee
5853-02B1	22,837	DIAMOND, Milton	University of Hawaii
5876-02B1	30,800	WINSBOROUGH, Halliman H.	University of Wisconsin
5948-01A1	35,000	WALLACH, Edward E.	Pennsylvania Hospital
5953-01A1	28,510	GRAY, Robert M.	University of Utah
5971-01A1	43,815	SWIGAR, Mary E.	Yale University School of Medicine
5985-01A1	23,350	PHILLIPS, Llad	University of California, Santa Barbara
6036-01	29,621	WHITE, Martha S.	University of California, San Francisco

<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
6040-01A1	\$ 47,515	THAU, Frederick E.	City College of the City University of New York
6075-01A1	35,645	LOSCHKY, David J.	University of Missouri-Columbia
6077-01A1	30,897	HOCHSTASSER, Donald L.	University of Kentucky
6088-01A1	15,327	ESHLEMAN, J. Ross	Western Michigan University
6130-01A1	41,528	JEFFE, Abram J.	Columbia University
6226-02	53,342	DANIEL, Joseph C.	University of Tennessee
6230-01	18,180	KATHAN, Ralph H.	Hektoen Institute for Medical Research
6244-01A1	36,628	EVANS, James S.	University of Tennessee
6298-01A1	31,050	DAVIS, Brian K.	Worcester Foundation for Experimental Biology
6315-02S1	8,588	SCHUMACHER, Gebhard F.	University of Chicago
6316-03	40,000	STEINBERGER, Emil	University of Texas Medical School
6336-01	25,325	ROSE, Leslie I.	Peter Bent Brigham Hospital
6372-01A1	29,998	MCCORMACK, Shirley A.	Tulane University
6378-01	12,040	EKANEM, Ita Inyang	University of Ife
6428-01	113,220	BRUNSWICK, Anne F.	Columbia University
6433-01	21,653	MACISCO, John J.	Georgetown University
6462-01	26,430	SPROTT, Richard L.	Jackson Laboratory
6488-01	20,000	LEAVITT, Wendell W.	University of Cincinnati
6488-01A1	28,192	LEAVITT, Wendell W.	University of Cincinnati
6512-01	34,569	EPPEL, Gisela M.	University of Pennsylvania
6530-01A1	12,793	CARRIER, Oliver, Jr.	University of Texas Medical School
6532-01A1	53,678	MCGAUGHEY, Robert W.	Arizona State University

<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
6539-01	\$ 4,940	HARPER, Dean H.	University of Rochester
6555-01	30,095	ARIMURA, Akira	Tulane University
6557-15	20,732	BRADBURY, James T.	University of Iowa
6593-01	7,840	MUHSAM, Helmut V.	Hebrew University
6594-01	18,289	BROCKELMAN, Warren Y.	New York University
6596-01	18,771	PIANTADOSI, Claude	University of North Carolina
6612-01	30,738	DeJONG, Gordon F.	Pennsylvania State University
6622-01	14,203	MOORE, Michael	University of California, Davis
6630-01	46,506	HUNTER, JoAnne S.	University of Michigan
6641-01	19,550	BERNSTEIN, Maurice H.	Wayne State University
6643-01	32,408	HAMNER, Charles E.	University of Virginia Medical School
6654-01	72,198	LEVINE, Arnold J.	Emory University
6656-01	38,656	MENON, K. M.	University of Michigan
6657-01	39,573	COULOPOULOS, Diane T.	Simmons College
6660-01	34,763	RESKO, John A.	Oregon Regional Primate Research Center
6661-01	26,519	NEAVES, William B.	Harvard Medical School
6663-01	80,000	METZ, Charles B.	University of Miami
6683-01A1	17,175	OZAKI, Hironobu	Michigan State University
6690-01	23,594	GARDNER, Peter M.	University of Missouri
6693-01A1	16,573	LEATHEN, James H.	Rutgers University
6698-01	32,511	MEIZEL, Stanley	University of California, Davis
6698-01A1	39,452	MEIZEL, Stanley	University of California, Davis
6700-01	11,336	HATHAWAY, Ralph R.	University of Utah
6713-01	46,171	KAYE, Jerome S.	University of Rochester
6715-01	30,152	KAMBYSELLIS, Michael P.	New York University

<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
6715-01A1	\$ 30,183	KAMBYSELLIS, Michael P	New York University
6718-02S1	8,500	HANSEL, William	Cornell University
6722-01	4,900	PARKS, Alfrieta V.	Princeton University
6746-01	123,800	MORRIS, John M.	Yale University
6748-01	21,930	FLICKINGER, Charles J.	University of Virginia
6752-01A1	21,901	BLISS, Eugene L.	University of Utah
6758-01	146,000	UDRY, J. Richard	University of North Carolina
6759-01	40,000	GOSPODAROWICZ, Denis J.	Salk Institute for Biological Studies
6766-01	76,449	ELINSON, Jack	Columbia University
6771-01	14,927	MENDELS, Franklin F.	University of California Los Angeles
6777-01	36,831	SUD, Bhupinder N.	St. Christopher's Hospital for Children
6785-01	28,180	EHRlich, Edward M.	University of Chicago
6787-01A1	38,746	JACKSON, Gary L.	University of Illinois
6801-01	16,790	HUDSON, John C.	Northwestern University
6802-01	27,636	UDIS, Bernard	University of Colorado
6821-01	62,500	SINGH, Ram N.	Marshall University
6836-01	8,596	CLARKE, Carl T.	University of Florida
6859-01	10,235	HOLZBERG, Jules D.	Wesleyan University
6865-01	4,999	WEISSENBERG, Peter	State University of New York
6870-01	16,446	VOOGT, James L.	University of Louisville
6877-01	18,761	MEIBURG, Charles O.	University of Virginia
6879-01	43,604	DAS GUPTA, Prithwis	University of Minnesota
6896-01	24,600	FULLER, Gene E.	University of Southern Mississip
6898-01	22,019	JOHNSON, Haldor T.	Medical University of South Carolina

<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
6899-01	\$ 26,696	BURDEN, Hubert T.	East Carolina University
6901-01	33,505	PRATT, Lois V.	Jersey City State College
6916-01A1	191,676	BIGGERS, John D.	Harvard Medical School
6924-01	23,321	DICKMANN, Zeev	University of Kansas Medical Center
6926-01	16,042	RODGERS, Charles H.	University of Illinois
6933-01	30,291	BULL, Christopher M.	Institute for Community Studies
6935-01	25,523	HOBBS, Daryl J.	University of Missouri
6948-01	26,238	HAFS, Harold D.	Michigan State University
6950-01A1	43,450	HAGINO, Nobuyoshi	Southwest Foundation for Resear and Education
6955-01	35,216	CHOW, Lien P.	Johns Hopkins University
6955-01A1	35,448	CHOW, Lien P.	Johns Hopkins University
6964-01	1,826	OSWALT, Robert T.	Skidmore College
6965-01	27,359	VANECKO, James J.	Brown University
6968-01	5,000	VORA, Mahasukhrai N.	Harvard University
6969-01	26,055	DYM, Martin	Harvard Medical School
6972-01	25,300	WARREN, James C.	Washington University
6978-01	12,365	SCHNATZ, Paul T.	Case Western Reserve University
6980-01	39,021	ABRAHAM, Guy E.	Harbor General Hospital
6981-01	32,000	GONDOS, Bernard	Harbor General Hospital
6982-01	25,965	BLAHA, Gordon C.	University of Cincinnati
6983-01	30,000	HUGHES, Edward C.	State University of New York
6987-01	19,726	CHEN, Chao-ling	Kansas State University
6990-01	40,982	FICHER, Miguel	St. Christopher's Hospital for Children
7001-01	25,085	SYKES, Zenas M.	Johns Hopkins University

<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
7002-01	\$ 5,140	von BROEMSEN, Max H.	Washington State University
7009-01	37,981	GUNTER, Billy G.	University of South Florida
7017-01	18,200	SNOOK, Robert B.	Iowa State University
7025-01	22,045	NASH, Ethel M.	University of North Carolina
7029-01	39,299	KALLEN, David J.	Michigan State University
7038-01	31,441	LAMB, Neven P.	Portland State University
7040-01	41,435	BUSE, Rueben C.	University of Wisconsin
7043-01	21,101	CARR, William J.	Beaver College
7046-01	25,115	SMITH, B. Dianne	Harvard University
7046-01A1	26,771	SMITH, B. Dianne	Harvard University
7049-01	53,000	LUTTGE, William G.	University of Florida
7064-01	4,925	DANIELSEN, Albert L.	University of Georgia
7068-01	33,227	MEL, Howard C.	University of California, Berkele
7094-01	14,665	LI, Wen L.	Ohio State University
7095-01	14,713	CROUCH, Robert L.	University of California Santa Barbara
7097-01	92,425	WENDT, Paul F.	University of Georgia
7098-01	64,509	ISARD, Walter	Cornell University
7099-01	18,814	SETTLAGE, Diane S. F.	Women's Hospital
7111-01	75,687	TREIMAN, Donald J.	Center for Policy Research
7112-01	31,870	COHEN, Malcolm S.	University of Michigan
7116-01	4,066	CVETKOVICH, George T.	Western Washington State College
7118-01	28,260	COBLINER, W. Godfrey	Albert Einstein College of Medic
7121-01	15,000	BO, Walter J.	Wake Forest University
7122-01	22,000	MARTAN, Jan	Southern Illinois University
7144-01	15,319	REYNOLDS, Robert J.	University of Idaho
7147-01	103,232	MARKS, Eli S.	University of Pennsylvania

<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
7149-01	\$ 87,211	BERGSMAN, Joel	The Urban Institute
7183-01	42,255	HORNSTEIN, Harvey A.	Center for Policy Research
7186-01	27,053	BAWDEN, D. Lee	University of Wisconsin
7189-01S1	11,160	NACE, George W.	University of Michigan
7194-01	25,876	SCHROEDER, Paul C.	Washington State University
7198-01	27,530	JOBES, Patrick C.	University of Colorado
7211-01	12,000	EISEN, Eugene J.	North Carolina State University
7231-01	33,763	LI, Ting-Kai	Indiana University
7239-01	27,205	CHEESMAN, Dean W.	University of California, San Francisco
7242-01	26,974	BURKE, William H.	University of Minnesota
7244-01	34,979	AMANN, Rupert P.	Pennsylvania State University
7259-01	23,789	FECHHEIMER, N. S.	Ohio State University
7268-01	48,520	DAVID, Henry P.	American Institute for Research
7273-01	38,450	STYCOS, William A.	Worcester Foundation for Experimental Biology
7285-01	24,180	INKELES, Alex	Stanford University
7286-01	27,524	WILSON, Wilbor O.	University of California, Davis
7287-01	40,000	KALRA, Satya P.	University of Florida
7312-01	22,274	MANDELL, Betty K.	University of South Carolina
7323-01	72,366	BECKMAN, Linda J.	University of California Los Angeles
7334-01	31,858	HAMOVITCH, William	Queens College of CUNY
7336-01	26,884	HERMAN, William S.	University of Minnesota
7349-01	11,170	FITZPATRICK, David	California State College
7356-01	39,310	STUMPF, Walter E.	University of North Carolina
7363-01	12,281	COLE, Steven G.	Texas Christian University

<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
7365-01	\$ 58,343	ERICKSON, William	University of Missouri
7370-01	23,528	MODIANO, Nancy	Catholic University of America
7373-01	66,230	SOGHKIAN, Krikor	Kaiser Foundation Research Institute
7392-01	27,081	JONES, Grant D.	Hamilton College
7398-01	13,811	JOYCE, Jon M.	Wesleyan University
7400-01	28,193	DEMERS, Laurence M.	Harvard Medical School
7401-01	33,016	BEAR, Richard S.	University of North Carolina
7413-01	56,446	WISCHNITZER, Saul	Yeshiva University
7420-01	18,576	WOODS, James E.	DePaul University
7429-01	31,280	MACDONALD, Gordon J.	Harvard Medical School
7451-01	4,858	KAUFFMAN, David E.	Southern Methodist University
7462-01	30,828	CUNHA, Gerald R.	Stanford University
7468-01	25,000	KAROW, Armand M.	Medical College of Georgia
7480-01	31,330	KAY, Margarita A.	University of Arizona
7487-01	27,770	HUXTABLE, Ryan J.	University of Arizona
7488-01	29,787	LISK, Robert D.	Princeton University
7489-01	43,699	BECK, R. Lee	University of Alabama
7492-01	26,707	WEINER, Richard I.	University of Texas
7496-01	26,284	CARTER, Carol Sue	University of Illinois
7499-01	19,499	NORMAN, Reid L.	Oregon Regional Primate Research Center
7519-01	7,645	SCHWARTZ, Steven	Northern Illinois University
7520-01	83,093	ALTES, Jane A.	Southern Illinois University
7532-01	14,955	SIMON, Julian L.	University of Illinois
7534-01	38,640	DUKELOW, W. Richard	Michigan State University
7546-01	15,446	STRYKER, Josiah D.	Tufts University

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<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
7550-01	\$155,087	BLOCH, Eric	Albert Einstein College of Medicine
7561-01	25,000	CUNNINGHAM, William P.	University of Minnesota
7565-01	78,760	DAY, Richard H.	University of Wisconsin
7576-01	49,850	CURRY, John J.	Boston University
7579-01	118,197	GOLDSTEIN, Sidney	Brown University
7589-01	25,000	GUERIGUIAN, Jean L.	University of North Carolina
7596-01	9,236	COOK, William D.	Tulane University
7597-01	15,183	CLARK, Margaret P.	University of Alaska
7599-01	17,275	HAINES, Michael R.	Cornell University
7603-01	34,931	BINKLEY, Sue A.	Temple University
7605-01	91,942	YETT, Donald E.	University of Southern California
7607-01	24,694	NEWELL, Laura L.	University of Washington
7615-01	31,978	SNYDER, Leon A.	University of Minnesota
7621-01	66,382	GUSTAVUS, Susan O.	University of Utah
7632-01	34,620	GRAHAM, Edmund F.	University of Minnesota
7644-01	31,600	MATHER, Frances J.	Tulane University
7645-01	31,265	CORNWALL, John L.	Southern Illinois University
7655-01	34,138	HUCKINS, Claire	Baylor College of Medicine
7656-01	53,161	PALMER, Keith H.	Roger Williams General Hospital
7663-01A1	25,021	DICKMANN, Zeev	University of Kansas
7674-01	32,468	JOSHI, Sharan G.	Southwest Foundation for Research and Education
7683-01	31,360	MACDONALD, Gordon J.	Harvard Medical School
7684-01	11,935	QUADAGNO, David M.	University of Kansas
7690-01	31,000	KELCH, Robert P.	University of Michigan

<u>Grant Number</u>	<u>Direct Cost Amount</u>	<u>Investigator</u>	<u>Institution</u>
7710-01	\$ 30,000	MOGHISSI, Kamran S.	Wayne State University
7720-01	24,530	BLACKER, Antonie W.	Cornell University.
7722-01	28,980	GALA, Richard R.	Wayne State University
7726-01	25,100	NABERS, Lawrence	University of Utah
7729-01	31,796	MENON, K. M.	University of Michigan
7739-01	64,717	ROSEN, Ruth A. H.	Wayne State University
7741-01	42,000	MARKERT, Clement L.	Yale University
7762-01	37,753	BUTCHER, Roy L.	West Virginia University
7789-01	31,656	KUTNER, S. Jerome	Institute for the Study of Soci: and Health Issues
7791-01	25,910	VAN TIENHOVEN, Ari	Cornell University
7801-01	40,000	GIVENS, James R.	University of Tennessee
7812-01	21,380	KOHORN, Ernst I.	Yale University
7817-01	33,194	HOROWITZ, Donald L.	Smithsonian Institution
7824-01	22,350	KLAPPER, Michael	Ohio State University
7825-01	4,992	OPLER, Marvin K.	State University of New York, Buffalo

TOTALS - FY 1973

255 research grants

DIRECT COST APPROVALS	\$8,836,678
INDIRECT COST ESTIMATE @ 27.8%	<u>2,456,596</u>
TOTAL COST	\$11,293,274

COMMITTEE OF DOCTORS AND NURSES VS. ABORTION

EXECUTIVE COMMITTEE

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O'LEARY & O'LEARY
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30-23-148 STREET
FLUSHING, N. Y. 11354

EFFECTS OF ABORTION AND CONTRACEPTION ON PUBLIC HEALTH

The state of N.Y. has felt the full impact of a law that legalizes Abortion on demand. The impact was so impressive that within a two year period the legislators of our state voted to repeal this law, an unheard of precedent. Our young women had been mutilated, experimented with, sterilized and killed. We learned the hard way, there is no such thing as a nice safe sterile abortion. The intent of the law had been to do away with back alley abortions. This did not happen. Deaths from illegal abortions rose and the deaths from legal abortions have outnumbered the deaths from the back alleys.

Although the complications of abortion have been well documented by Dr. Jean Fakter from the N.Y.C. Dept. of Health, the public has not been informed of the true facts. An edited version presenting a distorted picture, given out by Mr. Gordon Chase of the N.Y.C. Health Dept., is all that is available to the public. The original report has been denied even to the members of the medical profession by Mr. Chase's office.

The public was lead to believe that the number of deaths from abortion had been reduced in N.Y. second year of experience which is untrue. Further we must remember that deaths from illegal abortions have increased, and as far as legal abortion go every death represents an increase since we started from zero. No mention was made either by Mr. Chase of the complications of abortion, although they are explicitly categorized and listed in "The Bulletin on Abortion", which is published monthly by the N.Y.C. Health Dept. Hemorrhage, infection, perforated uterus, anesthesia, shock, retained tissue, failure to abort, lacerated cervix, and others (hysterectomy).

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30-23 - 148 STREET
FLUSHING, N. Y. 11354

Medical Periodicals and papers have been saturated with articles pertaining to the dangers and complications attributed to the procedure of Abortion, yet none of these have been made known to the general public.

The long term side effects of abortion are multiple .Japan, who has had 24 yrs experience with liberalised abortion and who is now desperately trying to revert to the old restrictive law, reports the following long time complications:

- 1) 9% Sterility.
- 2) 14% subject to habitual spontaneous miscarriage.
- 3) 400% increase in tubal pregnancies
- 4) 17% Menstrual irregularities
- 5) 20-30% Abdominal pains, dizziness , headaches etc.

Saline abortions had been outlawed in Japan over 20 years ago due to the high mortality and morbidity of this procedure, yet it is one of the chief methods of abortion in the U.S. today, although we have found the same facts to be true from our own studies. (documentation presented to support this statement and future statements)

The utilisation of public funds to foster abortion and contraception is a grievous misappropriation of funds in the field of Public Health .With easy abortion and contraceptives available to our young unmarried there exists neither responsibility for sexual behavior, nor a fear of pregnancy. It is for this reason that venereal disease has become pandemic throughout our nation. In 10-15 Years our nations Mental Institutions will be insufficient to house the victims of latent Syphilis .In less

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than five years the major worry of our country will be sterility as an inevitable aftermath of gonorrhea and abortion. If we had looked at the results of other nations who have used abortion and contraception as a means of solving social problems - Japan Hungary, Sweden, Denmark, Greece - we should have learned from their mistakes.

Tidal waves of young unmarried pregnant women are still with us. Abortions have outnumbered births in New York State this year. Up to the present date society has pressured these mothers to terminate their pregnancies. Steps can easily be taken to provide positive solutions to this problem such as:

1. Stop the media from spreading the fallacy that the new amorality is the "In Thing".
2. Stop so called Family Planning Programs from setting up offices in our High Schools and Colleges.
3. Establish Child Life Centers to help problem pregnancies.
4. Require Health Insurance companies to provide full maternity benefits as they now provide full coverage for abortion.
5. Establish federal support for children with congenital defects.

The argument heard most often from those who would like the government to undertake massive funding of birth control programs is that we need to make contraceptive information and devices available to every person who might possibly want them, because only by this means can we check the spread of venereal disease.

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As I said previously, it is certainly true that venereal disease is a problem of pandemic proportions in the U.S. today. But it is equally true that programs that Senate Bill 1708 would fund do not help to solve the problem ---- they contribute to it.

The logic behind this judgment is very simple. Venereal disease is rampant when promiscuous sex is rampant. And promiscuous sex is increased in direct proportion to the spread -- indeed the aggressive promotion -- of contraceptive propaganda to more and more people, in younger and younger age brackets. The young and the unmarried are the central targets of many of the programs and organizations that S 1708 would fund. Yet it is precisely because of promiscuous sex among these outside a stable marriage relationships that venereal disease is rampant. This Bill would make the situation worse. Even the Inter-Planned Parenthood Fed. claims "the pill" spreads V D.

In addition to the spread of venereal disease the side effects of the contraceptives themselves such as the pill, foam and the abortifacient I.U.D. have been found to be detrimental to the human body itself. Serious side effects after the procedure of vasectomy have been documented. (see documented evidence)

As we are all aware pregnancy occurs at the time of ovulation. Simultaneously at this time there is a rise in alkaline phosphatase in the blood. A simple saliva test was developed several years ago which determines this rise in the blood. It has deliberately been kept off the market in the U.S. although it has been used overseas.

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This test has been found to be simple, foolproof, can be bought over the counter for pennies and has no side effects on the human body whatsoever. The introduction of this test to the public would automatically eliminate the hazardous contraceptives that are being fostered by Planned Parenthood. The results of this method was documented even in the lay press. (Diners Club Magazine Feb. 1972) I believe an investigation by your Committee and the Dept. of Health, Education and Welfare is in order and I would appreciate a written report on the results of such an investigation. I would further urge every Committee member to read the results of such an investigation before voting any action on this bill.

Another argument that supporters of programs like this make is that we need to have government backing the contraceptive hard-sell in our Society to eliminate the tremendous demand for abortion.

Now this argument would be a little more believable if the people making it were against abortion--if, for example, they would eliminate abortion, and abortion counseling, and abortion referrals, and dispensing of abortifacients from their programs. We know that they are not about to do this, so we have to question the depth of their concern about the abortion scandal.

Even if we take the argument at face value, we must conclude that massive government support of birth control is no way to reduce abortions. In fact, as in the case of venereal disease the evidence points the other way.

One of the best round ups of evidence available on the connection between contraception and abortion is contained in Professor Germain Grises's book, "Abortion:

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The Myths, The Realities and The Arguments". Analyzing the available data Professor Grises concludes: "Abortion in the developed countries --that is those such as the U.S. and Great Britain that are industrialised and urbanised to a high degree-- seems to be a secondary method of birth control. Contraception is preferred, and abortion is used most often when contraception fails. So true is this that the spread of birth control, at least up to the last very few years, seems to have been accompanied by the increase of abortion. Birth control, rather than counteracting abortion, actually has seemed to aggravate the problem."

To sum up, we must recognize that Senate Bill 1708 is going to aggravate the abortion and venereal disease problem. It is our opinion, as doctors and nurses who have been personally involved with the situation in the state of New York, that the solution to eradication of venereal disease put forth by Planned Parenthood has already been tried and found wanting, both in this country and abroad.

Our National Government has done a great injustice to the youth of this country in the field of public health. We should take measures now to correct this injustice. Remember the youth of today are the future leaders, policy makers and home makers of our country. We have a responsibility to protect their health.

From a medical point of view Bill 1708 is definitely detrimental to the health and welfare of this Society.

Respectfully submitted to the Senate Committee on
Labor and Public Welfare

Ada R. Ryan M.D.

President 5,000 Doctors and Nurses vs. Abortion
(State of New York)

May 23, 1973

**STRATEGIES FOR ACCOMMODATING
AMBULATORY CARE PROJECTS
UNDER MEDICARE AND MEDICAID**

**Department of Health, Education, and Welfare
Office of the Assistant Secretary
For Planning and Evaluation/Health Evaluation
Contract No. HEW-OS 72-169**

MACRO SYSTEMS, INC.

March, 1973

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EXECUTIVE SUMMARY

As one element of a strategy to stimulate better health services delivery to underserved populations, the Health Services and Mental Health Administration (HSMHA) started several years ago to give financial support to innovative forms of ambulatory care centers. In most cases, this support was explicitly or implicitly in the form of developmental grants (often called "seed money" or "front-end" grants).

The theory was that, once the centers were well established, they would generate substantial income from other sources, particularly from various third parties who reimburse providers of health services to designated beneficiaries. The start of the HSMHA grant program coincided roughly with the enactment of Titles XVIII (Medicare) and XIX (Medicaid) as amendments to the Social Security Act. These two programs provide assistance in paying the medical costs of the aged and poor, respectively. Because these two segments of the population were expected to be the dominant clientele of the ambulatory care centers, it was presumed that the centers should be able to derive a major share of their income requirements from Medicare and Medicaid reimbursements, and the need for HSMHA grant support should decrease correspondingly.

Such terms as "independence" and "self-sufficiency" appear regularly in various planning documents. The most decisive statement appears in the

DHEW plan for Fiscal Year 1973 in which HSMHA Objective #4 is stated as:

"To develop and implement by June 30, 1973 in all HSMHA programs and HSMHA-supported health service delivery projects a fiscal management policy replacing Federal project grant support with increased third-party reimbursement and other cost reimbursable devices."

Most ambulatory care centers have been operating long enough that, if self-sufficiency is a normal and easily attained stage of development, many would have attained it already. There are no reliable data on the status of all the centers collectively in this respect, but a few spot checks and other fragmentary evidence suggest that centers rarely are deriving a significant proportion of their total income from third-party reimbursements. Until now, however, the underlying reasons for this apparent shortfall in Medicare and Medicaid collections have not been studied thoroughly and systematically.

1. MACRO SYSTEMS, INC., WAS ENGAGED TO DEVELOP STRATEGIES FOR MAXIMIZING LEGITIMATE THIRD-PARTY COLLECTIONS BY CENTERS

In a series of projects for HSMHA, MACRO SYSTEMS, INC. (MSI), studied the performance and practical problems in collecting third-party reimbursements of a limited number of ambulatory care centers. Learning of this experience, the Office of the Assistant Secretary for Planning and Evaluation, Division of Health Evaluation (OASPE/HIE), engaged MSI to combine this prior experience with a thorough study of Medicare and Medicaid statutes and regulations, to identify barriers to the flow of third-party reimbursements from the two programs to the ambulatory care centers.

If such barriers were found, MSI was further to develop strategies, embracing legislative, regulatory, and administrative action, as appropriate, to reduce or remove the barriers, and was to project the financial impact of the strategies.

The boundaries of the charge to MSI were defined in five ways:

- OASPE/HE designated five types of ambulatory care centers on which the study was to concentrate: Neighborhood Health Centers, Maternal and Infant Care Projects, Children and Youth Projects, Family Planning Projects, and Community Mental Health Centers.

Because few ambulatory care centers deal in significant numbers with patients eligible for benefits under private health insurance plans, the study was to focus exclusively on Medicare and Medicaid as third-party payers.

- Planning reportedly is well advanced for a substantial HSMHA technical assistance effort to all centers, so MSI recommendations regarding technical assistance were to be carried only to the point of indicating areas in which the need for such assistance is imperative.
- Previous HSMHA and MSI studies indicate that centers controlled by hospitals or other parent health service organizations have comparatively much less difficulty in collecting third-party payments, so the emphasis of MSI work was to be on "free-standing" centers.
- Because there are virtually no reliable data on the current status of ambulatory care centers with respect to third-party collections, projections of financial impact were to be refined only to the point of being indicative for broad-scale budgetary planning but not for grants management or budgetary control of individual centers.

2. MSI CONCLUDED THAT SELF-SUFFICIENCY BASED ON THIRD-PARTY COLLECTIONS IS NOT AN ATTAINABLE GOAL WITHIN EXISTING SYSTEM CONSTRAINTS

After a thorough analysis of the interface between the ambulatory care centers and the two medical payment programs, MSI concluded that third-party collections by the centers can be increased substantially within the constraints imposed upon all the programs involved, but not to the point where the centers can even approach self-sufficiency based on these sources of income. Only a considerable liberalization of the patient eligibility and benefit structure provisions of Titles XVIII and XIX, a possibility not considered in this study, would reverse this basic conclusion.

Specifically, MSI estimated that the ambulatory care centers collectively are now deriving no more than roughly 10 percent, and probably nearer five percent, of their total income from third-party collections. * Unless the basic program concepts of the centers are changed radically, as outlined later, the centers collectively probably cannot expect to derive more than about 20 to 25 percent of their income from this source. Even that level will require a considerable effort to attain.

* Individual centers may vary widely from this average. Many centers collect no third-party reimbursements. A few centers, operating in situations which cannot be replicated broadly, may have, in fact, achieved self-sufficiency.

3. CURRENT EXPECTATIONS ARE UNREALISTIC PARTLY BECAUSE OF FOUR BASIC MISCONCEPTIONS ABOUT THE NATURE OF THE SYSTEM

In reviewing prior work on this subject, and particularly various planning documents underlying current DHEW policy statements, MSI became aware of four misconceptions running as themes through much of that work.

(1) Pivotal Goals of the Delivery and Payment Programs Diverge More Than Is Commonly Acknowledged

Most studies of the problems of the ambulatory care centers start with the assumption that the goals of the centers and of the medical payment programs are essentially congruent, and that most of the services of the centers therefore should be reimbursable under either Medicare or Medicaid. This is not the case.

- The ambulatory care centers were set up to render a comprehensive range of outpatient services to patients regardless of their means of payment.
- The Medicare program was established to reimburse aged people for the costs they incur for a limited range of medical services. The emphasis is on inpatient treatment of acute illnesses, which excludes most of the preventive and social services rendered by ambulatory care centers. Furthermore, the benefits of greatest interest to the centers are available only to those who enroll voluntarily for Part B benefits.

The Medicaid program was established to assist poor people to defray, but not necessarily to underwrite totally, the costs of necessary medical services. Eligibility under the program is restrictive and volatile.

Thus defined, it is evident that there is some overlap of the goals of the three programs, but it is more coincidental than intentional. In practice, Medicare and Medicaid payments to ambulatory care centers cover a smaller percentage of the care rendered than in the case of other providers: ambulatory care centers serve significant numbers of people not covered by either payment program; and many of the services that are provided to those who are eligible are excluded from payment by both programs.

(2) Medical Payment Programs Are not Administered Nationally or Uniformly as Often Assumed

Basic policies for both Medicare and Medicaid were established by the Congress and are interpreted in regulations and directives issued from the national offices of the Bureau of Health Insurance (BHI) and the Medical Services Administration (MSA). The decisions most critical to the centers are made, however, at the State and local level, and there is substantial variation in actual administrative practice.

Regulations and instructions governing the medical payment programs are highly complex. They have been written mostly around the situations encountered with conventional providers, and there is little generalized experience to guide decisions related to ambulatory care centers. Day-to-day administration of both programs has been highly decentralized, and effective management information systems to monitor compliance and uniform administration have not been established.

Consequently, there is no central point to which the centers have been able to turn for authoritative interpretation or intervention.

(3) The Importance of Medicare to Ambulatory Care Centers Is Discounted Incorrectly

Only two of the five types of centers considered in this study ever encounter Medicare patients, and even these centers typically have less than 20 percent of their patients eligible for Medicare benefits. Furthermore, Medicare coverage does not include routine preventive services, the primary elements in the service programs of the ambulatory care centers. Moreover, few centers make strong efforts to collect Medicare reimbursements because, at best, they represent only a marginal source of potential income.

For all these reasons, the importance of Medicare to ambulatory care centers has been consistently discounted. This attitude overlooks the strong, although indirect, influence of Medicare administration on Medicaid administration. Few of the State agencies assigned responsibility for Medicaid administration have prior experience in administering a large-scale, comprehensive medical payment program and, faced with rapidly escalating costs, naturally looked to the Medicare program for appropriate administrative constraints. In designating providers eligible for reimbursement, for example, actual experience has established the fact that most centers which acquire recognition from the Medicare

program have little difficulty in establishing eligibility for Medicaid reimbursement, but centers which have been denied Medicare recognition may have parallel difficulty with Medicaid.

(4) Neither the Ambulatory Care Centers Nor the Payment Programs Have Recognized Fully Their Mutual Responsibilities

The relationship between the ambulatory care centers and the medical payment programs has been characterized by misunderstanding and consequent mistrust on all sides. It appears that both the payment programs and the centers have contributed to this condition.

The payment programs have been uncertain about the status of the centers and disturbed by the contrast between their operations and those of conventional providers. Rather than moving rapidly and directly to resolve these problems, they have resorted more often to administrative delay and non-communication.

At the same time, the centers have been preoccupied by service and community relations problems and have not attempted diligently to secure maximum third-party reimbursements. Few center billing staffs understand benefit structures well and consequently may submit many erroneous claims. The centers often are unable to respond competently to reasonable requests for cost data. Many seem not to appreciate that they must meet a high measure of accountability if they expect reimbursement from third parties.

4. THIRD-PARTY REIMBURSEMENTS ARE SHARPLY LIMITED BY FIVE FACTORS

Careful analysis of the interface between the centers and the payment programs demonstrates that the flow of reimbursements is controlled fully by five factors. As indicated below, the centers have experienced varying degrees of difficulty with each of the five:

- Provider Status--The centers cannot claim reimbursement unless they are recognized as providers or provider-equivalents by the payment programs. MSI finds no statutory or regulatory barrier to this recognition and no evidence of a systematic intention to exclude them. Yet, many free-standing centers still are not recognized, partly because they have not pursued this status diligently and competently, and partly because State agencies and carriers have delayed recognition because of uncertainty about the application of the regulations to specific cases. In a few instances, payments have been withheld because the propriety of reimbursements to Federally funded projects has been questioned.
- Patient Eligibility--The centers can be reimbursed only when they serve patients eligible for benefits under the Medicare or Medicaid programs, other third-party payment plans, or patients who pay for all or a part of the services rendered. A large percentage of the patients of most centers are not eligible for Medicare or Medicaid, however, either because they do not qualify for enrollment or because they have not applied for enrollment. The latter is particularly common in centers which charge no fees whatever to patients, regardless of ability to pay.
- Benefit Structures--The centers can be reimbursed only for services specifically designated as covered under one of the programs. Reflecting their comprehensive care concepts, centers typically provide many services excluded from coverage under Medicaid and, particularly, Medicare.

Rate Structure--The programs are neither designed nor obligated to pay the full cost of covered services. Medicare has deductible and coinsurance amounts that the patient is expected to pay. The gap between cost and reimbursement rate is often quite large, particularly under Medicaid in so-called "poor" States.

Billing Efficiency--Centers are reimbursed only when they submit claims accurately and promptly, and few free-standing centers perform adequately in this respect. Efficiency is essential internally, too, in that the cost of claims preparation is an offset to the gross amounts collected, and even fewer centers have efficient billing systems.

The effect of these factors is compounded in application, i. e., the factors act in sequence, each reducing in turn the potential reimbursements already reduced by the prior factors. The cumulative effect is that the centers collectively probably are now realizing no more than 10 percent of their income, possibly closer to five percent, from third-party collections.

5. ONE DHEW OPTION WOULD BE TO CONSTRICT SERVICES TO REIMBURSABLE SERVICES ONLY

One possible direction DHEW could take to change this situation would be to induce the centers to limit their services to only those for which reimbursement can be expected. This would require a sharp constriction of the range of services offered and a denial of service to patients not eligible under either payment program, unless benefits and eligibility were expanded substantially by enactment of a National Health Insurance program.

Even this action would not result in self-sufficiency unless the payment programs were directed concurrently to reimburse for service at 100 percent of cost. Nevertheless, this is a feasible and available option, even though it would thoroughly vitiate original ambulatory care program concepts. Strong community reaction could be expected.

Implementation would require nothing more than simple amendment of enabling legislation for project grants and of the corresponding regulations, limiting the purposes for which Federal project grants could be used.

6. A MORE MODERATE COURSE WOULD INCREASE REIMBURSEMENTS SIGNIFICANTLY BUT NOT PUT SELF-SUFFICIENCY WITHIN REACH

As an alternative, DHEW could elect to preserve the comprehensive service approach of the centers but take action to maximize third-party reimbursements. As demonstrated in Chapter V, reimbursements could be increased roughly fourfold; but at this higher level, they still would represent only about 20 to 25 percent of the centers' required income.

This strategy would require a carefully orchestrated blend of legislative, regulatory, and administrative action. The latter would be mainly in the form of a large-scale program of technical assistance to the centers, constructed around all five of the factors listed earlier; although its cost would be high, the program should yield positive cost benefits in terms of increased collections.

A major step toward resolving many of the problems of the Medicare program already has been taken in the Bureau of Health Insurance's recent decision to reimburse most free-standing ambulatory care centers from the Division of Direct Reimbursement in Baltimore. This should alleviate much of the non-uniformity and uncertainty that has appeared until now in Medicare administration. Beyond this, the following legislative and regulatory action might be taken with respect to the Medicare program:

- Publish the criteria for the classification of these facilities as either hospital-controlled or free-standing physician-directed clinics so that ambulatory care centers may understand the basis for qualification for reimbursement under either classification.
- Develop and publish instructions for reimbursement of covered Part B Medicare services for Federally funded, free-standing ambulatory care centers, modeled after the Principles of Reimbursement applicable to Part A providers at 20 CFR Subpart D, sections 405.401 through 405.488.

One desirable administrative action related to the Medicare program only would involve a reconfirmation by the Secretary of the support his four predecessors gave to the exemption, provided by regulation 20 CFR 405.252, and 20 CFR 405.312(f), from the provisions of Title XVIII (section 1862(a)) which prohibit reimbursements to Federally funded projects.

With respect to the Medicaid program, the Federal government has less control over the specific structure of State plans. Nevertheless, the following legislative and regulatory actions would remove some existing barriers to the flow of reimbursements:

- Broaden existing statutes and regulations which mandate "cooperative arrangements" between State programs and Title V projects, to include all HSMIIA-funded projects
- Mandate coverage of "clinic services" in all State Medicaid plans, and consider increasing Federal matching share for such services
- Require States to stipulate in considerable detail, as part of their State Medicaid plans, the basis on which they intend to establish rates

Beyond these actions which apply to the two programs separately, a program of technical assistance should be mounted to deal with problems common to both programs. This program might include the following elements:

- Rapid survey of the centers to identify those which have not yet been recognized as eligible for reimbursement by Medicaid and, if appropriate, Medicare; and direct regional office intervention with the appropriate State agency or carrier, with BHI and MSA support, to establish such recognition
- Development at the national level of a codification of the services typically offered by ambulatory care centers, and use of this codification to specify precisely what services are covered under Medicare and each of the State Medicaid programs
- Establishment of a monitoring system under which each center reports quarterly on claims rejected for reasons not fully understood; and use of these reports both to monitor State agency and carrier conformance to stated benefit structures, and to plan further training of center staffs in claims preparation

- Assistance to centers in developing accounting systems which provide information adequate for documentation of rate requests
- Development of simple systems to capture essential summary data on distribution of both user populations and encounters by payment source
- Encouragement and active promotion of an all-inclusive "statistical visit charge" based on cost
- Development of "packaged" billing systems and patient eligibility screening procedures applicable to various types of centers
- Encouragement of patient billing under sliding-fee schedules where they are not now used
- Amend the Medicare law to change requirements for assignment of claims by patients, to establish that such assignment is not needed in centers recognized as providers or provider-equivalents
- Effective training of selected center staff personnel in eligibility screening, benefit structures, accounting procedures, claims preparation, and other billing procedures

This second strategy is less disruptive to existing programs but will not lead to full self-sufficiency among the centers. If implemented effectively, nevertheless, it can result in a nearly fourfold increase in the level of third-party collections, an increase which would more than offset the substantial costs of implementation.

**A FIVE-YEAR PLAN FOR
FAMILY PLANNING SERVICES AND POPULATION RESEARCH**

**Second Progress Report to the
CONGRESS OF THE UNITED STATES**

Pursuant to Section 5

Public Law 91-572

May 1973

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE



THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

May 17, 1973

TO THE CONGRESS OF THE UNITED STATES

In accordance with the requirements of the Family Planning Services and Population Research Act of 1970 (PL 91-572), I am pleased to submit the Second Annual Progress Report on the Five-Year Plan for Family Planning Services and Population Research.

This report reflects the Administration's belief that the proper Federal role in family planning as in other health areas is one of support, not domination. In the long run, the Federal role is to reduce financial barriers. Our purpose is to enable public agencies at the State and local level to discharge their necessary responsibilities and to assure that private initiative and resourcefulness are given the opportunity to serve the health needs of the vast majority of Americans.

Swapski
Secretary

Enclosure

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INTRODUCTION

This is the second progress report submitted in compliance with Section 5(a) of PL 91-572, the Family Planning Services and Population Research Act of 1970. The Act requires submission of a Five-Year Plan not later than six months after passage of the legislation and annual progress reports on January 1 for each year of the plan.

The increase in Federal, State, and local involvement in family planning services during the last five years is remarkable. Five years ago, no Federal funds were specifically earmarked for support of family planning services. Liberalization of State laws was necessary in many cases in order to allow family planning services to be generally available. Family planning services are now regarded as an integral part of comprehensive health services and have received Presidential emphasis. President Nixon established as a national goal the provision of family planning services to all those who want them but cannot afford them. Also recognized is the need for additional research on birth control methods of all types and the sociology of population growth. Congress has provided significant financial support for these programs.

Fiscal Year 1973 is the third full year of the family planning services and population research Five-Year Plan submitted to Congress in 1971. This report covers progress through FY 1972 and presents plans for the period FY 1973-75.

Highlights of Activities--1967 Through 1972

1. The first Deputy Assistant Secretary of HEW for Population and Family Planning was appointed in August 1967.
2. In September 1967, a Consultants' Report on "Implementing DHEW Policy on Family Planning and Population" was submitted delineating appropriate actions to implement family planning programs in the Department.

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3. On January 2, 1968, President Lyndon B. Johnson signed the Social Security Amendments of 1967 (PL 90-248), which included the Child Health Act of 1967. This Act established categorical project grants for family planning services and required that not less than 6 percent of the monies appropriated for Maternal and Child Health under Title V be obligated for family planning services.
4. On July 16, 1968, President Johnson appointed an Advisory Committee on Population and Family Planning under the Co-chairmanship of Secretary Wilbur J. Cohen and John D. Rockefeller, III. The Committee submitted its report, "Population and Family Planning: The Transition from Concern to Action," to the President in November. The Committee made a series of recommendations for Federal action in population research and family planning services, both at home and abroad.
5. In August 1968, the Center for Population Research was established within the National Institute of Child Health and Human Development.
6. On July 18, 1969, President Nixon sent to Congress his message on population growth and the American future. The message called for the establishment of a Commission on Population Growth and the American Future, additional research on birth control methods of all types and the sociology of population growth, and established as a national goal the provision of adequate family planning services within five years to all those who want them but cannot afford them.
7. In October 1969, the Secretary of HEW established the National Center for Family Planning Services within the Health Services and Mental Health Administration.
8. On March 16, 1970, President Nixon signed the Act establishing a Commission on Population Growth and the American Future.

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9. On December 7, 1970, the Secretary's Advisory Committee on Population Affairs was formally established.
10. On December 24, 1970, President Nixon signed into law the "Family Planning Services and Population Research Act of 1970" (PL 91-572).
11. On October 12, 1971, the Secretary submitted to the President a Five-Year Plan for Population Research and Family Planning Services, as required by the Family Planning Services and Population Research Act of 1970 (PL 91-572).
12. On January 1, 1972, the National Center for Health Statistics instituted a modified and improved National Reporting System for Family Planning Services for use by all federally supported family planning programs, clinics and service points, and by other agencies who wish to participate in the reporting system. This system provides data for the efficient and effective development, operation, and evaluation of family planning programs throughout the Nation.
13. In February 1972, the Secretary submitted the first Progress Report on the Five-Year Plan for Family Planning Services and Population Research to the Congress.
14. On March 27, 1972, the Commission on Population Growth and the American Future submitted its report to the President.
15. On October 30, 1972, President Nixon signed the Social Security Amendments of 1972, PL 92-603. This Act made the informing of the availability and the provision of family planning services mandatory to all present and to certain former or potential recipients of AFDC who are of childbearing age. The Act imposes a penalty of one percent per annum on the Federal share of AFDC funds on States which failed to provide these services in the previous year to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Title IV-A -- AFDC -- to 90 percent from 75 percent and increases the Federal share for family planning services under Title XIX -- Medicaid -- to 90 percent from a variable formula with a range from 50 to 83 percent Federal matching.

This report consists of progress reports from the agencies of the Federal Government engaged in population research, family planning services, and related activities.

POPULATION RESEARCH

I. Introduction

In July 1969 President Nixon called for Federal action to solve population problems. "First," he said, "increased research is essential. It is clear... that we need additional research on birth control methods of all types and the sociology of population growth. Utilizing its Center for Population Research, the Department of Health, Education, and Welfare should take the lead in developing, with other Federal agencies, an expanded research effort, one which is carefully related to those of private organizations, university research centers, international organizations, and other countries."

"Second," said the President, "we need more trained people to work in population and family planning programs, both in this country and abroad."*

The President's proposals involved population research and training programs conducted or supported by the Center for Population Research (CPR) of the National Institute of Child Health and Human Development, as well as by other public and private agencies.

The mission of population research is to develop methods of fertility regulation which are safe, effective, and likely to be used, and to understand the motivation for their use. Many organizations are involved in this research. Their activities reflect the diverse nature of population problems and the complexity of research efforts in this field.

A. Principal National Agencies

Within the Department of Health, Education, and Welfare, the Center for Population Research (CPR) of the National Institute of Child Health and Human Development has primary responsibility for population research. Population Research Table 1 shows the population research budget for NICHD since FY 69 and demonstrates a growth from \$11.5 million in FY 69 to \$39.8 million in FY 73.

An initial assignment of the Center for Population Research upon its establishment in 1968 was to provide information on all Federal population research activities. The result was a report entitled "The Federal Program in Population Research," which was prepared by CPR under the sponsorship of The Federal Council for Science and Technology through the Ad Hoc Group on Population Research.

The appointment of the Deputy Assistant Secretary for Population Affairs placed responsibility for coordination of Federal population research activities in the Office of the Secretary. This duty was redelegated to the CPR by a directive of the Secretary dated October 5, 1970. The order established the Interagency Committee on Population Research (ICPR) which was to produce annual reports and analyses of population research programs.

*R. M. Nixon, "Problems of Population Growth." The President's Message to Congress, July 18, 1969.

POPULATION RESEARCH TABLE I
 NICHD POPULATION RESEARCH BUDGET
 (in millions)

	FY 69 (Actual)	FY 70 (Actual)	FY 71 (Actual)	FY 72 (Actual)	FY 73 (Estimated)
TOTALS	11.5	18.7	28.4	40.0	39.8
Research Projects	8.8	15.3	24.3	33.4	32.8
Contraceptive Development (including reproductive biology)	(6.5)	(11.6)	(15.0)	(22.7)	(22.6)
Evaluation of Contraceptives	(1.3)	(1.6)	(3.2)	(5.5)	(5.1)
Social Sciences	(1.0)	(2.1)	(6.1)	(5.2)	(5.1)
Center Core Support			0.3	1.6	2.0
Training	2.4	2.7	3.0	2.8	2.5
Scientific Information Services				0.2	0.2
Staff Support (including scientific and technical information)	0.3	0.7	0.8	2.0	2.3

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The Food and Drug Administration of DHEW is involved in the population research field through its responsibility for ensuring the safety and effectiveness of contraceptive drugs.

The Agency for International Development in the Department of State has a population research program as part of its mission of providing assistance to developing countries. AID allocations for population research have increased from an average \$1 million annually in fiscal years 1965-1968 to \$10.2 million in fiscal 1970, \$13.1 million in fiscal 1971, and \$13.5 million in fiscal 1972.

The major private agencies engaged in population research are the Rockefeller Foundation, The Population Council, and the Ford Foundation. The Rockefeller Foundation supports university population centers as well as research and training in reproductive biology, demography, and family planning. The Population Council conducts and supports basic and applied research on the biomedical and behavioral aspects of population including contraceptive development, social science research, operational research, and analysis of population policies. The Ford Foundation supports research and training in population and family planning, research and demonstration programs to improve family planning services delivery, and dissemination of information on population problems.

Such pharmaceutical companies as Mead Johnson, Parke Davis, G. D. Searle, Syntex, and Upjohn conduct basic research on contraception and applied research on contraceptive product development.

B. Estimated Cost Projections

Population Research Table 2 is an estimate of the funds available in FY 71 and FY 72 and a projection for FY 73 through FY 75 from Federal and nonprofit American agencies. These estimates do not include the participation of universities, the pharmaceutical industry, and other for-profit organizations.

POPULATION RESEARCH TABLE 2

FIVE-YEAR COST PROJECTIONS FOR POPULATION RESEARCH

By American Non-Profit and Federal Agencies
(In Millions of Dollars)

	FY 1971 (Estimate)	FY 1972 (Estimate)	FY 1973 (Projected Range)	FY 1974 (Projected Range)	FY 1975 (Projected Range)
Totals	70-80	80-100	100-150	130-190	150-220

The estimates for FY 71 and FY 72 were derived from DHEW, AID, the Ford Foundation, the Rockefeller Foundation, and The Population Council. The projections for FY 73-FY 75 are not intended to commit the funding agencies.

C. Five-Year Goals

Population research activities of both the public and private sectors may be divided into Biomedical Research and Behavioral Sciences Research. A description of these two broad categories and the specific areas which they subsume follows:

1. Biomedical Research involves targeted and basic investigations of all aspects of human and animal reproductive processes, development of new or improved methods of fertility regulation, and evaluation of the safety and effectiveness of current contraceptives.
2. Behavioral Sciences Research consists of directed and fundamental studies of the economic, social, and psychological determinants and effects of population growth and change and the relation of various cultural factors to fertility.

The population research efforts of the National Institute of Child Health and Human Development encompass both areas of research involvement and represent the scope of current population research of all United States agencies. Immediately following is a detailed report of the achievements and current status of the NICHD research program.

II. Progress Report of Population Research Programs:

National Institute of Child Health and Human Development

Primary responsibility for Federal efforts to improve contraceptive technology and to increase understanding of the biological and behavioral aspects of population growth and change rests with the National Institute of Child Health and Human Development (NICHD) and its Center for Population Research (CPR).

This report describes research relating to new contraceptive agents, evaluation of current contraceptive methods, and analysis of social factors in population problems. The report also describes the Institute's fundamental research in reproductive biology and the social sciences which facilitates its achievement of targeted research goals. Finally, the report describes the NICHD programs of institutional support, research manpower development, and information. Names in parentheses indicate the NICHD grantees, contractors, and intramural scientists whose findings are mentioned.

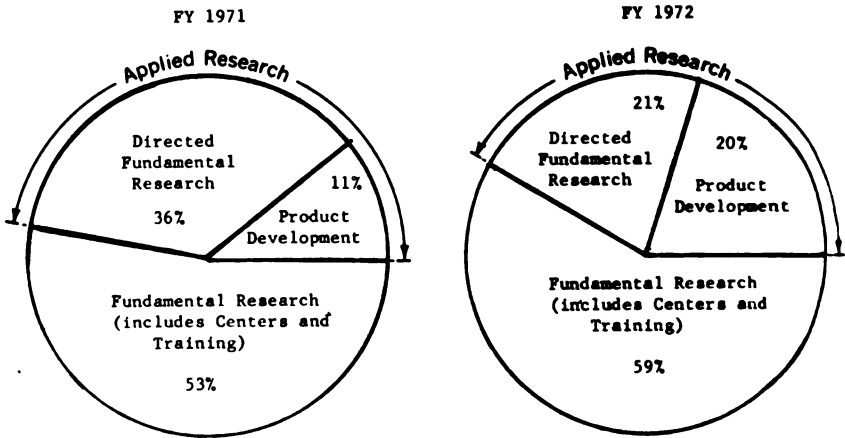
Population research may be divided into Fundamental Research, Directed Fundamental Research, and Product Development. Population Research Figure 1 shows the relative emphasis devoted to each of these three areas by the NICHD in FY 1971 and 1972:

1. Fundamental Research includes: a. Grant-supported, investigator-originated research to develop basic knowledge in the biomedical or behavioral sciences; b. Support of training in the population sciences; c. Provision of core facilities to research centers. Fundamental research is the basis for devising and achieving targeted research goals. Currently the NICHD commits an approximately equal amount of funds to fundamental and to applied research, (53% vs. 47% in FY 1971, and 59% vs. 41% in FY 1972). The percentage of funds in the fundamental research areas grew from 53% in FY 1971 to 59% in FY 1972 primarily as a result of the award of several large grants to Population Research Centers.

2. Directed Fundamental Research refers to research to develop specific information which is essential prior to further steps in the scientific process. Such research is contract-supported, program staff-initiated, and focused on a particular end point. This type of research provides the transition between fundamental research and the development of specific products. The percentage of total NICHD funds expended for this type of research was reduced from 36% in FY 1971 to 21% in FY 1972 in order to direct additional resources into product development.

3. Product Development is research to identify, synthesize, and test compounds or devices with potential antifertility effects. It includes testing of compounds or classes of compounds of known contraceptive activity, synthesis of analogs of contraceptive compounds to eliminate unwanted side-effects, and development of devices for permanent or temporary sterilization. Strengthened capability of the staff in this field has enabled the NICHD to increase its efforts from 11% of overall FY 1971 funds to 20% of FY 1972 funds. Notable in this category during FY 1972 was the establishment of a drug testing facility.

POPULATION RESEARCH FIGURE I
NICHD POPULATION RESEARCH PROGRAM DISTRIBUTION



A. Biomedical Research

1. Contraceptive Development

The Five-Year Plan suggested types and levels of research required to develop a variety of methods of fertility regulation which are effective, safe, and acceptable to various population groups. The plan called for: (a) drug development and testing, (b) development of new or improved contraceptive devices and systems, and (c) directed biomedical research in targeted areas. The relative level of effort devoted to each of these three elements is a result of several factors: the possibility of fairly rapid advance in certain areas such as device development but not in others such as drug development, NICHD priorities, and the types of research being undertaken by other nonprofit and industrial agencies.

Drug Development

The drug development program--the synthesis and testing of anti-fertility agents--has been in operation since June 1971 and in part involves the synthesis of new compounds which are expected to show antifertility activity with a minimum of side effects. By June of 1972, twelve contracts were awarded, dealing with unusual prostaglandin analogs¹, unique steroidal compounds², and the preparation and testing of hypothalamic releasing factors³ and their analogs. One contract (White) involves the preparation of substantial amounts of the luteinizing hormone-releasing hormone (LH-RH)⁴. By January 1973, approximately 4.0 grams will be available for distribution through the National Pituitary Agency, the major low cost source of this important substance.

The substitution of silicon for carbon in steroids used for contraception may affect their biological activity by separating their anti-fertility activity from their other hormonal (estrogenic) activity (Tanabe). Since the hormonal activity of steroids frequently causes side effects, a separation of these two activities is desirable. This kind of activity manipulation may, in addition, eventually permit development of a postcoital or antioviulatory agent of greater potency than currently available.

1 Prostaglandins which are changed by the addition or subtraction of chemical groups.

2 The group of compounds to which sex hormones belong.

3 Hormones secreted by the hypothalamus which affect reproductive function.

4 The hypothalamic factor which controls the release of luteinizing hormone (LH), the hormone which triggers ovulation.

NICHD also supports the synthesis of prostaglandin-like compounds (Fried and Revesz). Such drugs might act as luteolytic⁵ agents and thus may become once-a-month pills. A problem with certain naturally occurring prostaglandins⁶ as contraceptives has been their characteristic of producing uterine contractions. Several of the new compounds have now been tested, and at least one has shown significant antifertility activity in animals, with little accompanying smooth muscle activity.

The NICHD has also emphasized developing methods for male fertility regulation. Subcutaneous implantation of the male sex hormone testosterone completely inhibits sperm production in rabbits without affecting potency or sex drive (Ewing). Inhibition of spermatogenesis (sperm formation) can be achieved with combinations of drugs possessing progestational (female) and androgenic (male) activities. The progestational component inhibits sperm formation while the androgenic drug maintains the male sex drive. Clinical trials of combined drugs as male contraceptives have been reported, and the Institute plans to sponsor similar work.

To uncover new leads in drug development, the NICHD established a testing facility for chemical compounds being synthesized with government, drug industry, and other funds. This work has begun at the Mason Research Institute in Worcester, Massachusetts. Out of an annual review of some 5,000 compounds of varying chemical structure, the staff of the Center will select approximately 300 to be evaluated during the first year.

Device and Systems Development

The development of devices for reversible blockage of the sperm carrying channel (vas deferens) has progressed to the point of testing various devices in guinea pigs and dogs (Brueschke, Freund, Nuwayser). Implantation of the devices in the closed position blocks sperm passage. In the open position, the devices allow free sperm passage. A major problem to be resolved concerns the occasional failure of the device to adhere to the vas lining. When this happens, sperm granulomas (inflamed tissue) may form, leading to a variety of complications.

5 Agents which cause regression of the corpus luteum--the ovarian structure formed following discharge of the ova. The corpus luteum produces progesterone, a hormone necessary for the maintenance of pregnancy. The noun form is luteolysis.

6 A family of naturally occurring compounds found in most body tissues.

Significant strides have been made in the development of devices to block the oviducts⁷ in women, although again, implementation of the human program must await further animal experimentation. For example, placement of plugs in the oviducts requires adequate visualization of the tube openings. For this purpose, an instrument has been built which permits seeing the interior of the uterus and the junctions between the uterus and oviducts. The instrument can be steered, allowing investigators to examine the uterine cavity in detail and, theoretically, to place tubal plugs. Placement of plugs in female baboons is planned during FY 73.

The eventual development of new contraceptives will depend in large measure on NICHD support. However, the biological and regulatory complexity of bringing new contraceptive drugs to the point of extensive human trials makes this a long-term enterprise. The device and drug delivery projects are closer to the human experimentation stage than are the drug development studies so that we can anticipate possible selective human testing in these areas within calendar year 1973.

Directed Biomedical Research

Product development is shaped by directed fundamental research to the extent that the latter exploits likely leads. The directed portion of our program provides the NICHD and the scientific community with information explaining factors regulating normal reproductive processes, and suggesting new avenues for controlling them. Work underway includes studies of the following as described below.

The Oviduct. The effect of the oviduct's movements on the passage of ova is being studied.

Prostaglandins. Basic research into the interaction of prostaglandins with the reproductive system is continuing in order to understand their action and potential usefulness.

Spermatozoa and Fertilization. In the epididymis, the male sex hormone, testosterone, is converted to another hormone called dihydrotestosterone (Amann, Eik-Nes). Dihydrotestosterone may be required for the maturation of sperm. Prevention of the transformation could control fertility.

7 The tubes through which ova pass from the ovaries into the uterus.

Sperm possess several enzymes need for penetration and thus fertilization of the ovum. If enzyme antibodies capable of neutralizing sperm enzymes could be developed, they might prove useful as contraceptives.

2. Fundamental Biomedical Research

Most of the fundamental research in reproductive biology conducted in this country is supported at least in part by the NICHD. The increased knowledge of reproductive processes resulting from the work is essential for achievement of the Institute's program goals. Examples of efforts within this broad program are:

Studies of sex hormone receptors in hormone sensitive tissues.

Searching for drugs that act as hormone antagonists.

A laboratory technique has been devised using radioactive material which specifically discriminates between the pituitary hormone LH and the pregnancy hormone HCG (Ross). These assays are so sensitive that scientists can now detect HCG as early as 5 days after fertilization, making pregnancy detectable 5 weeks earlier than previously possible. The demonstration that HCG is present this soon after fertilization challenges traditional concepts and suggests either that implantation occurs earlier than previously believed (7-8 days after conception) or that HCG is produced by the blastocyst⁸ before implantation occurs.

3. Contraceptive Evaluation

Although this program is responsible for monitoring the medical effects of all contraceptives currently in use, oral contraceptives (OCs) have received major emphasis. Secondary efforts have been started on IUDs and vasectomy.

Oral Contraceptives

More than 12 years have elapsed since the general clinical introduction of oral contraceptive drugs. These drugs, while unsurpassed in clinical efficacy, have medical effects which are not limited to the reproductive system. Virtually every physical characteristic that can be tested is found to be influenced to some degree by use of oral contraceptive drugs. Even more important are rare adverse effects. Although projected morbidity and mortality rates are low, the widespread use of these drugs means that the absolute number of women affected to some extent will be large.

Much concern has been related to thromboembolism with most initial information derived from individual case reports submitted to industry and the

8 A stage of development of the fertilized ovum.

Food and Drug Administration (FDA). Studies to evaluate the risk were initiated in 1965 by NIE and the FDA. As a result, the FDA called for a major revision of product labeling in 1968. Subsequent studies have suggested that thromboembolism risks are dose-dependent, adding further refinement to risk estimates.

NICHD monitors oral contraceptives through a general surveillance program and specific studies related to carcinogenicity, possible genetic effects, fundamental pharmacology, comparative pharmacology, adverse cardiovascular effects, and increased risk of stroke in women of reproductive age.

Intrauterine Devices

Recent study results support the hypothesis that the IUD alters the uterine environment in such a manner that blastocysts are destroyed or are not able to stay in the uterus until an estrogen surge permits implantation (Chang). If the IUD is removed before day 4 of pregnancy, there is an improved likelihood of survival of the fertilized ovum.

Vasectomy

The acceptance of sterilization by males has been increasing rapidly. Although this contraceptive method is effective, isolated reports suggest the possibility of changes in the immunologic system. Similar effects on antibody production have been demonstrated in limited animal studies. A program to detect possible complications from male sterilization and to identify the mechanisms by which such complications might occur was initiated during late FY 72.

B. Behavioral Sciences Research

The goals of the NICHD behavioral sciences program in population research are: (1) to ascertain the social, psychological and economic determinants of fertility; and (2) to expand our understanding of the consequences of population growth and change so that public policy may be guided by adequate information.

Since fertility is the most significant component of population change, it has received the highest priority. Particular emphasis is given to the causes of changes in fertility patterns. Current studies concern the psychological, social, and economic factors which affect fertility and the differences in fertility patterns among population groups in the United States. These studies include:

Fertility in the United States. With industrialization and urbanization, fertility in the United States declined. Following World War II, however,

the birth rate rose until 1958, and then began to decline. A series of studies since 1955 has attempted to document changing family-size preferences of American women and other factors affecting their fertility.

Data from the most recent of these, the 1970 National Fertility Study, reveal an increased use of the most effective methods of fertility control. In addition, there was a drop in the rate of unwanted fertility between the early and latter 1960's, to about 35 percent for white and 56 percent for blacks (Westoff, Ryder, and Bumpass).

The decline in unwanted births was chiefly due to the increase in use of the pill, IUD, and sterilization from 37 percent in 1965 to 58 percent in 1970. By 1970, nearly 6 million, or one in five, married women of reproductive age were using OCs. Increased reliance on surgical procedures (about 2.75 million or 1 in 6 couples by 1970) suggested that many couples who had completed their families preferred sterilization to temporary contraception.

While the National Fertility Study covers only married women, Johns Hopkins University is conducting a study of the sexual behavior, contraceptive practices, fertility and nuptiality of females at ages 15-19 (Zelnick and Kantner).

As part of the NICHD plan to study attitudes toward specific contraceptives, four hundred women and men from three communities have been selected for a study of the psychological effects of vasectomy (Pohlman). This investigation should help in evaluating the present and potential role of vasectomy as a means of birth control.

Attitudes toward abortion are also under study. This investigation should increase understanding of the effects of liberalization and provide insight into the motives and decisions of pregnant women undergoing either abortion or delivery.

Trends in Fertility and Factors Contributing to Fertility Decline.

Fertility declined in western Europe and elsewhere in response to social changes associated with industrialization and urbanization. However, declines in fertility have occurred in dissimilar circumstances in different countries. Part of the behavioral sciences research has, therefore, been directed toward studies of fertility decline with emphasis upon the socioeconomic conditions under which it occurred.

Consequences of Population Growth. Behavioral research on the consequences of population growth and change, for example, the consequences of increasing numbers of individuals, higher density, and changing age distributions, has been accorded high priority.

Migration is one of the chief means by which populations adjust to social and economic change, and is a major component of population change. To

identify the conditions which bring about migration and to define its consequences, several studies have been undertaken. They will increase our understanding of problems of depopulation as well as overpopulation.

During FY 1973, the behavioral sciences program will expand research directed toward its major program goals: the development of new knowledge about the social, economic, and psychological determinants of fertility and about the consequences of population change. Several components of these areas will be stressed: (1) the consequences of childbearing and child spacing patterns for the individual and for the family; (2) the economic and environmental consequences of population change; (3) psychological factors influencing success in using various methods of fertility control; (4) the social and economic causes of the rise and fall of fertility in the U. S. in the period 1940-1970; and (5) the causes of low fertility among women of childbearing age of the 1920s and 1930s.

In addition to grant and contract support for biomedical and behavioral sciences research, the NICHD supports Population Research Centers and Program Projects and manpower development.

Population Research Centers and Program Projects

The Population Centers' research includes basic, directed, biomedical, and behavioral and concentrates on areas related to problems of population growth, structure, and distribution. The following six awards have been made to date:

1. The Center at Vanderbilt University;
2. The Population Research Center at the University of Texas;
3. The Population Council in New York;
4. The Center for Demography and Human Ecology at the University of Wisconsin;
5. The Biomedical Center for Population Research at the University of Chicago;
6. The Laboratory of Human Reproduction and Reproductive Biology at Harvard University.

A Program Project Award supports actual research, usually on an interdisciplinary basis, often within a Center. Program Projects in reproductive biology are presently being supported at the following nine major institutions in the United States: Columbia University, the University of Hawaii, Johns Hopkins University, the University of Michigan, Northwestern University, Ohio

State University, the Oregon Primate Research Center, the University of Pennsylvania, and the University of Texas at Austin.

Manpower Development

In the fields of population, Federal training support was provided annually for an estimated 280 scientists in training at any one time; about 80 of which graduated each year. Training support is also available through general educational assistance programs of the Office of Education, through payment for services on research grants and contracts, and through private sources.

The NICHD also gathers, analyzes, and disseminates scientific information. This is accomplished through the following mechanisms:

Research Inventory

The Interagency Committee on Population Research (ICPR), for which the NICHD has staff responsibility, has been extended for two years by the Secretary. This Committee has issued its third annual Inventory of Population Research Supported by Federal Agencies--Fiscal Year 1971.

This Inventory includes approximately 700 projects totaling more than \$100 million in funds. Of this total, the Department of Commerce reported the largest expenditure (\$47 million) in connection with compiling census data. The Department of Health, Education, and Welfare ranked second in dollar support (\$36 million) with more than two-thirds of this amount provided by the NICHD. Of the 700 projects, DHEW supported 80%, and NICHD's Center for Population Research funded 60%.

Research Analysis

The Analysis of Population Research Supported by Federal Agencies--Fiscal Year 1971 was also prepared by the ICPR. This three-part report utilizes the Federal Inventory as a data base. Part one reviews previous actions of the Committee and summarizes current population research funded by the Federal Government. Part two analyzes and evaluates ongoing biological and social science research. The third section contains recommendations concerning emphases in Federal programs. The Population Council and representatives of the Ford and Rockefeller Foundations are presently considering including a supplement to identify research projects funded by the three major private organizations.

Publications

Communication of population information is being assisted through the NICHD publication of Population Sciences: Index of Biomedical Research. NICHD may publish the Index monthly if the several additional experimental issues prove useful. This bibliographic journal is produced in cooperation with the

National Library of Medicine (NLM) using information from the Library's computer-based Medical Literature Analysis and Retrieval System (MEDLARS). For several years NICHD has helped support Princeton University's Population Index, a bibliographic journal devoted to population research in the social sciences. Population Sciences will provide a parallel service in the biomedical field.

To provide comprehensive coverage of biomedical literature, the NICHD has contracted with the Karolinska Institute in Stockholm to produce a Reproduction Thesaurus. The CPR is also initiating monographs in population research to review and evaluate progress in specialized areas of biomedical or social science population research.

Food and Drug Administration

Programs of the Food and Drug Administration (FDA) of DHEW are authorized by the Food, Drug and Cosmetic Act of 1938, as amended. The FDA is responsible for approving contraceptive drugs for safety and effectiveness before they are marketed and for maintaining surveillance over the drugs after their approval. The FDA involvement in the area of population research and family planning services lies primarily in:

- (1) Sponsoring research necessary to carry out FDA's regulatory responsibilities relating to the safety of oral contraceptives; and
- (2) Using the regulatory functions of the Agency to help assure safe and effective contraceptive drugs.

The first oral contraceptive agents were approved by the FDA for general use in 1961 after some years of research, testing, and evaluation. Studies are being carried out under contract to evaluate the experience of human populations utilizing oral contraceptives. FDA is supporting studies to evaluate various reported or suspected side effects in human and animal populations.

The activities of the FDA do not include provision of either services or training programs which might be utilized by the recipients in family planning projects. Of more direct concern to the FDA is the development of adequate information to assure the safety and effectiveness of those methods, both pharmacological and mechanical, which are being promoted by such programs. To this end, several projects are in progress.

Agency for International Development

Population research programs of the Agency for International Development (AID) within the Department of State are conducted under the 1968 Title I Amendment of the Foreign Assistance Act of 1961. AID funds are being used for support of family planning programs in 35 developing countries, for contraceptive and other supplies distributed to more than 70 countries, for development of new means of fertility control, and for support of population activities by the United Nations, the International Planned Parenthood Federation, and many other international organizations.

The goal of the AID research program is to develop and relate new family planning methods, new social science insights, and new distribution systems to incipient and on-going family planning programs of developing nations. AID funding for population research was \$10.2 million in fiscal 1970, \$13.1 million in fiscal 1971, \$13.5 million in fiscal 1972, and an estimated \$13.5 million in fiscal 1973.

AID emphasizes the following four functional areas in the field of population research:

1. Descriptive Demography. In the less developed countries of the world, census and vital registration data are frequently lacking or inadequate, and traditional methods of information gathering and analysis are not appropriate. AID is supporting the development of new methods for data collection relative to fertility, mortality, and migration, as well as innovative techniques for collecting and analyzing information concerning family planning practices, out-of-wedlock pregnancy, incidence of induced abortion, early infant deaths, family formation and dissolution, and patterns of childbearing and marriage. In fiscal 1972, AID awarded a \$1 million grant in partial support of the first two-year costs of a World Fertility Survey (WFS). The WFS is a five-year program to assist some 30 to 50 countries to carry out fertility surveys. To meet the need for improved demographic data and methods, AID has provided \$15.5 million for technical assistance and research projects between fiscal 1965 and fiscal 1972.
2. Determinants and Consequences of Population Characteristics and Change. To assist policy formulation and decision-making in less developed countries, AID supports investigations of the impact of government policies on population, e.g., tax laws, subsidies for child-rearing, policies concerning housing, agriculture, education and welfare, laws concerning legal age of marriage, and abortion laws. AID also supports social science research on population dynamics to elucidate factors operating at both the individual and societal level. AID funds for behavioral and social science technical assistance and research projects totaled \$13 million between fiscal 1965 and fiscal 1972.

3. Operational Research. AID supports research to assess the impact of family planning programs in less developed countries, including cost effectiveness of various delivery patterns, developing simplified and accurate means of keeping service statistics, new approaches to measuring the impact of service programs on fertility, better measures of the demographic effectiveness of specific contraceptives, and reasons for departure from theoretical effectiveness. From fiscal 1965 to fiscal 1972, AID provided \$15 million for over 60 technical assistance and operational research projects in 18 countries.
4. Improved Means of Fertility Control. In the less developed countries where health care systems are weak and the acceptor population is frequently poorly educated, it is important to develop fertility control techniques especially suited to the local conditions of these countries and less dependent upon sophisticated delivery systems. During fiscal 1965 to fiscal 1972, \$30 million has been obligated for fertility research in three areas: (a) Research to develop a once-a-month, self-administered method; (b) Research to improve currently available means of fertility control; and (c) Comparative clinical field trials of means of fertility control under use conditions in less developed countries.

FAMILY PLANNING SERVICES**I. Introduction**

The three major objectives of the family planning services program were established by legislation:

- PL 90-248, the Social Security Amendments of 1967, required each State to have a plan for extending family planning services to mothers in all parts of the State by July 1, 1975.
- PL 91-572, the "Family Planning Services and Population Research Act of 1970," was enacted to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services;...." Moreover, President Nixon, in his July 18, 1969 message to Congress, further defined this goal as, "The provision of adequate family planning services within the next five years to all those who want them but cannot afford them."
- PL 92-603, the "Social Security Amendments of 1972," requires States to make family planning services available Statewide on a voluntary and confidential basis, directly and/or on a contract basis, to all present and to certain former or potential recipients of cash assistance who are of childbearing age and who desire such services. A penalty of 1 percent per annum on the State's share of Federal AFDC funds is imposed if the State in the prior year fails to inform the adults in AFDC families of the availability of family planning services or fails to provide or arrange for such desired services.

To assist in accomplishing the first objective, the Congress established under Title V of the Social Security Act an authorization for project grants for family planning services and required that not less than 6 percent of the amounts appropriated for maternal and child health services formula

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grants, project grants, and research and training be obligated for family planning services. The amounts obligated under this authority have always exceeded the 6 percent minimum. In FY 1972, there were 120 family planning services project grants supported with \$27 million in funds from Title V. Sixty of these projects received funds from other Federal sources as well. In addition, 54 Maternity and Infant Care (M & I) projects provide family planning services to high-risk prospective mothers. These M & I projects provided family planning services to 120,284 individuals in FY 1972. See Family Planning Table 28. The States reported that the Maternal and Child Health Service Formula Grants supported in part family planning services for over 860,000 individuals during FY 1972. See Family Planning Tables 26 and 27.

Concurrently, the Office of Economic Opportunity was supporting the development of family planning service projects. These OEO supported projects have been, or are being, transferred to HEW for continuing support or consolidation with HEW financed projects.

To implement the objective enunciated by President Nixon in 1969, the National Center for Family Planning Services (NCFPS) was established. Responsibility for the administration of family planning services project grants was vested in the NCFPS. By the end of FY 1972, the NCFPS was financing 331 family planning services projects. Of these projects, 271 received funds authorized under Title X of the Public Health Service Act (PL 91-572, the Family Planning Services and Population Research Act of 1970). In FY 1972, over \$65 million were obligated under the Title X authorities for family planning services.

To assist in the implementation of the third objective, the Congress established a 90 percent Federal matching share for the offering, arranging, and furnishing, directly or on a contract basis, of family planning services and supplies under Title IV-A of the Social Security Act, Aid to Families With Dependent Children (AFDC). The Congress also mandated the 90 percent Federal matching share for Title XIX of SSA (Medicaid). The DHEW is encouraging the States to make use of the SSA Title XIX mechanism as the principal source of financial support for family planning services. The individual State plans will determine the goals and priorities for family planning services within each of the States. This aggregate of State and local activities will constitute the nationwide program.

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II. County Coverage and Service Levels by Organized Programs and Private Physicians; FY 1968 - FY 1972

A. County Coverage

Progress toward meeting the first objective has been rapid. By the end of FY 1972, subsidized family planning services were available to residents in 2,379 of the 3,099 counties and districts in the United States. These subsidized services were available to them either in their own county or through facilities in adjacent counties (Family Planning Table 1).

FAMILY PLANNING TABLE 1

GEOGRAPHIC COVERAGE AS OF JUNE 30, 1971 AND JUNE 30, 1972

Number of Counties	Counties With Organized Family Planning Services Available		FY 1972 Increase	Counties Without Organized Family Planning Services Available as of 6-30-72
	6-30-71	6-30-72		
3,099	2,039	2,379	340	720

The county coverage figures reported by NCFPS (Family Planning Table 1) are higher than those shown in the County Studies¹ (Family Planning Table 2) because NCFPS has included counties which do not have their own facilities but are located within normal commuting distance of facilities in adjacent counties. NCFPS estimated that at the end of FY 1972, about 90 percent of the low-income women projected to need subsidized family planning services in FY 1975 live in these 2,379 counties which have some services available. The existence of services does not mean that services are accessible to all low-income women in the area. Many existing services have limited capacity and are not within easy reach of all women in the area. These county statistics are presented only to indicate that at least a start has been made in providing subsidized family planning services in most areas

¹Three County Studies have been conducted, titled The Need for Subsidized Family Planning Services; United States, Each State and County, 1968, 1969, 1971.

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of the country. The percentage of counties considered to have some coverage increased from 65 percent in FY 1971 to 76 percent in FY 1972. As previously noted, many of the counties without coverage have only a few women identified as needing subsidized family planning services and are therefore low-priority areas.

FAMILY PLANNING TABLE 2

COUNTIES WITH ORGANIZED FAMILY PLANNING SERVICES
LOCATED WITHIN THEIR BOUNDARIES (FROM COUNTY STUDIES)

	FY 1968	CY 1969	FY 1971	FY 1972
Total Counties.....	3,072 ¹	3,072 ¹	3,072 ¹	3,072 ¹
Counties with organized services....	1,200	1,436	1,567	1,800 ²
Increase from prior period.....	---	236	131	233
Counties without organized services....	1,872	1,636	1,505	1,272

Progress toward the second goal to provide family planning services to all women who desire but cannot afford them is difficult to measure since many variables affect the number of women defined as requiring subsidized services. Such factors include population shifts, changing income levels, and variations in desired family size. Progress towards the achievement of the second goal is evaluated in Sections II-IV. Estimates of the number of women of childbearing ages 15-44 are shown in the following table. This table projects the number of low-income women who might need financial assistance to obtain family planning services. Projections are made for the poverty level, 125-percent-of-poverty, and 150-percent-of-poverty.

¹ Does not include districts in Alaska.

² Includes counties initiating services in FY 1972 reported by the MCFPS Regional Program Status Review.

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FAMILY PLANNING TABLE 3

NUMBER OF WOMEN AT VARIOUS LOW-INCOME LEVELS ESTIMATED
TO NEED SUBSIDIZED FAMILY PLANNING SERVICES
OVER 12 MONTH PERIOD, FY 1971-1975

	<u>Poverty</u>	<u>125-Percent- of-Poverty</u>	<u>150-Percent- of-Poverty</u>
FY 1971	3,166,000	4,531,000	6,073,000
FY 1972	3,226,000	4,618,000	6,189,000
FY 1973	3,293,000	4,713,000	6,317,000
FY 1974	3,361,000	4,811,000	6,448,000
FY 1975	3,432,000	4,912,000	6,582,000

Estimates will be revised periodically to reflect changes in the variables. Special 1970 Census tabulations of U.S. women aged 15-44 stratified by marital status and income level have been ordered. These statistics will be available in 1973, and will be used in next year's progress report. It is anticipated that the numbers of women in the categories above will be smaller.

Much of the current information in this report is from a study of all public and private family planning programs entitled Need for Subsidized Family Planning Services: United States, Each State and County, 1971,¹ (County Study, 1971), commissioned by the NCFPS, and the 1970 National Fertility Study,² supported by the Center for Population Research, NIH. The data for 1968 and 1969 are based on the earlier county studies.

Agency responses to the FY 1971 County Study (edited for income in accordance with the same procedure used in the earlier studies) show that 1.7 million women were receiving family planning services from organized programs as of June 30, 1971. Program growth from the beginning of FY 1968

¹ Conducted by the Center for Family Planning Program Development.

² Directed by Professors Norman B. Ryder and Charles F. Westoff of Princeton.

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to the end of FY 1971 covers three phases of development: (1) the period prior to major Federal involvement; (2) the period involving Federal participation under the 1967 legislation which affected local programs beginning in 1969; and (3) the period covered by PL 91-572, which was enacted in 1970 and accelerated program developments beginning primarily in FY 1972. The increases in service levels reported in Family Planning Table 4 do not represent new patients, but represent the net increase in the number of active patients, new patients less those who have dropped out.

FAMILY PLANNING TABLE 4

TOTAL PATIENTS REPORTED SERVED IN ORGANIZED
FAMILY PLANNING PROGRAMS, FY 1968 - FY 1971

Year	Source	Total Patients	18-Month Increase	
			Number	Percent
FY 1968	County Study	863,000
FY 1969	County Study	1,239,000	376,000	44
FY 1971	County Study	1,915,000	676,000	53

In Family Planning Table 5 and Figure 1, these data are interpolated to provide estimates for each fiscal year from FY 1968 to FY 1971, and the data are extrapolated to provide an estimate for FY 1972. In FY 1972 the total number of patients in organized family planning programs is estimated to have been 2,612,000.

FAMILY PLANNING TABLE 5

TOTAL REPORTED AND ESTIMATED PATIENTS SERVED IN ORGANIZED
FAMILY PLANNING PROGRAMS, FY 1968 - FY 1971

Year	Total Patients	Fiscal Year Increase	
		Number	Percent
FY 1968	863,000
FY 1969*	1,070,000	207,000	24
FY 1970*	1,410,000	340,000	32
FY 1971	1,915,000	505,000	36
FY 1972**	2,612,000	697,000	36

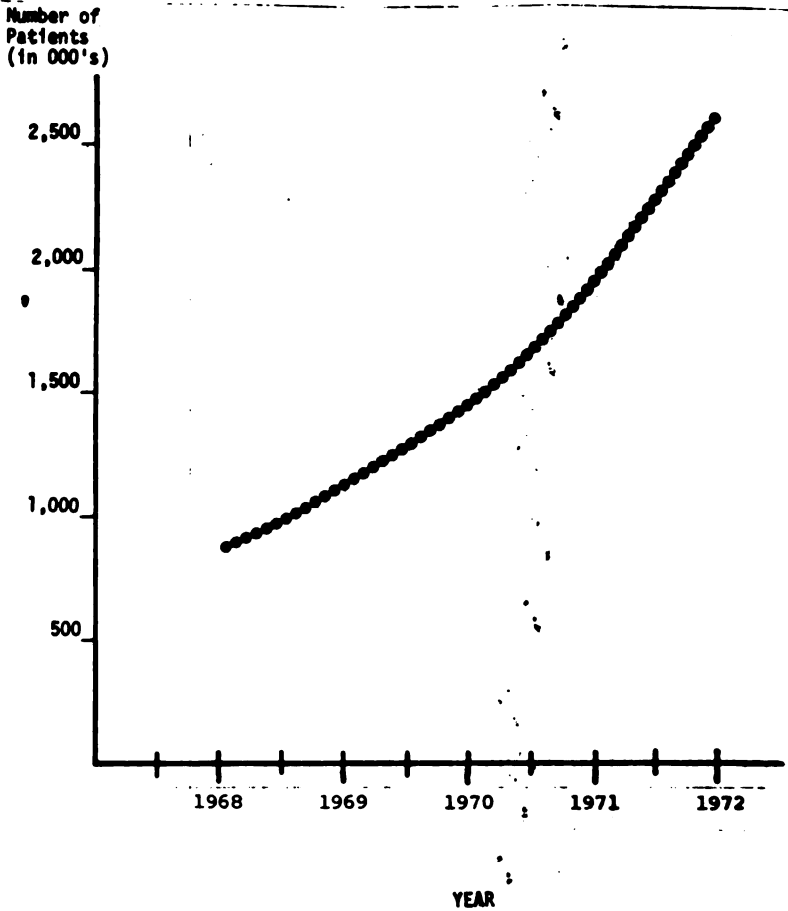
*Estimated by interpolation.

**Estimated by extrapolation.

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FIGURE 1

REPORTED AND ESTIMATED PATIENTS SERVED IN FAMILY
PLANNING PROGRAMS, FY 1968 TO FY 1972



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Organized programs served about 2,612,000 patients in FY 1972, three-quarters of whom were estimated to have incomes below 150-percent-of-poverty. Another 1,238,000 low-income women are estimated to have secured family planning care from private physicians in FY 1972.

Information from the 1970 National Fertility Study (NFS) and other sources has made it possible to improve previous estimates of the number of women served by private physicians. The NFS data are based on a representative sample of married women with husbands present (who comprise about 44 percent of all low-income women of childbearing age). Respondents to the survey were asked where they had secured their first prescriptions for pills, IUDs and diaphragms and whether they had visited a family planning clinic or discussed family planning with a physician in private practice in the last 12 months.

Based on the data shown in Family Planning Table 6, an estimated 25 percent of low-income married women available for contraception are receiving services from private physicians. The 1970 NFS also found that nonwhite married women used organized programs for family planning care more than white women with comparable incomes.

The NFS gives some indication about the number of low-income married women who receive family planning services from private physicians. A Johns Hopkins Study of Adolescent Sexuality, Contraception and Pregnancy¹ found that about 7 percent of sexually active teenagers in low-income families also secured contraceptive care from private physicians.

Using the estimates above for married women and teenagers, and assuming 10 percent of all unmarried and formerly married low-income women receive contraceptive care from private physicians, an estimated 19 percent of all low-income women probably received family planning services from private physicians in FY 1972. Private physicians are expected to serve a larger proportion of women each year. This proportion is projected to rise from 19 percent in FY 1971 to 25 percent in FY 1975.

¹ Directed by Professors John Kantner and Melvin Zelnik of Johns Hopkins and supported by the Center for Population Research, NIH.

FAMILY PLANNING TABLE 6

SOURCE OF FAMILY PLANNING CARE,
BY YEAR, RACE AND INCOME STATUS

	Percent of Respondents Available for Contraception 1/ Who Secured Family Planning Through:				
	Private Physi- cians in last 12 months	Organized Programs in last 12 months	Private Physi- cians before last 12 months	Organized Programs before last 12 months	Number of Women
Income Status and Race					
Low-income Status					
Total	24.6	12.8	19.4	4.6	611
White	27.5	9.6	21.0	3.1	415
Nonwhite	15.4	23.0	14.1	9.6	196
Other Income Status					
Total	35.0	3.1	25.3	2.5	3,349
White	36.0	1.9	26.3	2.0	2,941
Nonwhite	22.8	17.6	13.8	9.0	408

Source: 1970 National Fertility Survey

1. Excluding respondents who a) have had a sterilization operation; b) are currently pregnant or trying to become pregnant; c) are in the postpartum period; d) have arrived at menopause; and e) report that either they or their doctors are "sure they are probably sterile". For 354 respondents who were available for contraception and first used the pill or IUD in 1970, the source for care was determined by where they secured their first prescription in 1970. For all others, the source of care was determined by their answers to whether they had attended a family planning clinic or discussed family planning with a physician in private practice in the last 12 months or ever.

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Family Planning Table 7 summarizes the information from above concerning numbers of women served by organized programs and private physicians in FY 1972.

FAMILY PLANNING TABLE 7

LOW-INCOME INDIVIDUALS SERVED, FY 1972

	<u>Less Than Poverty</u>	<u>Less Than 125% of Poverty</u>	<u>Less Than 150% of Poverty</u>
Served in Organized Programs	1,437,000	1,724,000	1,959,000
Served by Private Physicians	484,000	764,000	1,238,000
Total Served	1,921,000	2,488,000	3,197,000

III. Characteristics of Patients in Organized ProgramsA. Income Characteristics

Data collected from organized programs indicate that they serve some women above 150-percent-of-poverty. Special tabulations from some agencies during FY 1972 show that 69 percent of individuals served in organized programs have incomes below 125-percent-of-poverty; 79 percent have incomes below 150-percent-of-poverty; and 90 percent have incomes below 200-percent-of-poverty (Family Planning Table 8). Although these data do not include all women served through organized programs, they do represent a substantial segment of the women served.

The 1970 National Fertility Study data indicated that birth rates were higher for low-income women (150-percent-of-poverty and below) than for women from families with incomes above this level. These women also characterized more of their births as unwanted at conception. Making available organized, subsidized family planning services to these women enables them to obtain the health, economic, and social benefits which accrue from voluntarily controlling their fertility.

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FAMILY PLANNING TABLE 6

DISTRIBUTION OF NEW PATIENTS IN SELECTED ORGANIZED
PROGRAMS BY POVERTY STATUS, 1969-71¹

System and Year	Cumulative Percentage of New Patients Below:			Number of Patients Covered
	125%-of- Poverty 2/	150%-of- Poverty 2/	200%-of- Poverty 2/	
<u>All Systems 1969-71</u>	69	79	90	936,366
National Center for Health Statistics Agencies				
Total 1969	74	83	93	642,308
1969	76	85	94	82,956
1970	76	84	93	216,619
1971	73	82	92	342,733
Planned Parenthood Agencies				
Total 1969-71	59	70	84	294,058
1969	57	70	84	75,814
1970	57	69	84	64,717
1971	62	71	85	119,380
<u>National Analysts Survey of Selected Projects, 1969 3/</u>				
All Patients	71	79	91	...
Patients with:				
Nonfarm income	70	78	90	...
Farm income	91	97	98	...
Patients in DHEW Projects	59	71	87	...
Patients in OEO Projects	79	86	94	...

1. Data are not necessarily representative of all patients reported to NCHS or of all Planned Parenthood Affiliates. NCHS data have not been validated.
2. The poverty levels employed in these tabulations are the Federal poverty indices published for 1969, 1970 and 1971 respectively.
3. Excluded from total of "All Systems 1969-71."

B. Other Characteristics

Data from various reporting systems covering 1.1 million patients were also used to assess other characteristics of women currently being served in organized family planning programs. These characteristics are summarized in Family Planning Table 9. The patients served are young (median age is 23, and five out of six are under 30). Four out of five have three children or less, and 30 percent have had no children. One out of six receives public assistance. More than half are high school graduates and more than one-third are nonwhites.

FAMILY PLANNING TABLE 9

**SELECTED CHARACTERISTICS OF
INDIVIDUALS RECEIVING FAMILY PLANNING SERVICES, 1971**

Characteristics	Composite of Reporting Systems*
Median age	23 years
Number of living children 3 or less (%)	82
Median grades of school completed	12
Grade school only (%)	17
High school graduates (%)	51
Some college (%)	17
<u>Race</u>	
White (%)	62
Nonwhite (%)	38
Receiving public assistance (%)	16

*Based on 1,130,241 case records.

IV. Services of Organized Programs

A. Types of Services Provided by Organized Programs

The National Center for Health Statistics (NCHS) national reporting system has made it possible to evaluate the extent to which the program provides fertility related preventive health care and entry into the health care system. The following analysis draws on nearly 800,000 patient records for calendar year 1971.

More than nine out of ten patients chose the most effective methods of contraception:

<u>Method Chosen</u>	<u>Percent</u>
Oral contraceptive	73
Intrauterine device	18
Jelly/Cream/Foam	4
Diaphragm	2
Other	3

The use-failure rates of pills and IUDs are only one-fourth to one-seventh as high as for other methods.¹ The function of the organized program in facilitating use of the more effective methods by young low-income couples is thus important from health, social, and demographic perspectives.

Patients also received the preventive health services shown below:

<u>Medical Service</u>	<u>Percent</u>
- a medical exam or at least one laboratory test	94
- pelvic examination	98
- breast examination	77
- other medical examinations	54
- Pap smear	79
- other laboratory tests	60

¹ L.A. and C.F. Westoff, From Now to Zero, Little-Brown, 1971, p. 69.

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All elements in the family planning delivery system appear to provide a high level of diagnostic health care to patients. Since over two million women are receiving subsidized services through organized family planning programs, they have become a major--perhaps the major--source of preventive health care for young, low-income, and largely healthy women of child-bearing age.

B. Service Levels by Type of Delivery Agency

Family planning services are provided by public and voluntary hospitals; State, county, and local health departments; voluntary agencies, and other organizations. In FY 1971, voluntary and other agencies served 41 percent of reported patients, health departments 36 percent, and hospitals 23 percent (Family Planning Table 10).

FAMILY PLANNING TABLE 10

PATIENTS SERVED BY TYPE OF PROVIDER AGENCY, 1969 AND FY 1971
(Patients in Thousands)

Type of Agency	CY 1969		FY 1971		Increase	
	<u>County Study</u>		<u>County Study</u>		<u>CY 1969 - FY 1971</u>	
	Number	Percent	Number	Percent	Number	Percent
Total	1,239	100	1,915	100	676	54.6
Hospitals	312	25.2	445	23.2	133	42.6
Health Departments	418	33.7	688	35.9	270	64.6
Voluntary and Others	509	41.1	783	40.9	274	53.8

V. Estimated Workload and Manpower Projections, 1973-1975

The objective of the Federal Government in subsidizing organized family planning services is to assist in the development of capacity to serve individuals who need assistance in obtaining such services. The Government encourages the

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existing health system to provide the required services through organized programs and private physician programs. Recent legislation has made family planning services a mandatory element of State Medicaid plans. The following workload and manpower projections incorporate information discussed earlier on the average annual rate of growth of organized programs since 1968, on typical retention rates for patients in selected programs, and on the proportion of low-income women receiving family planning care through physicians in private practice.

A summary of the FY 1972-75 projection is presented in Family Planning Table 11, which shows the service levels in FY 1972 and projects these levels forward through FY 1975. The projection assumes that the proportion of women served by private physicians will increase during the next three years as a result of numerous factors--greater information about, and legitimization of, family planning; removal of remaining legal and administrative barriers to family planning services; the trend toward public and private third-party reimbursement mechanisms to finance family planning care; and increased referral of patients to private physicians by organized programs.

Family Planning Table 11 shows that in FY 1972, an estimated 3.2 million low-income individuals were served by organized programs and private physicians. The caseload projected for each year in this progress report is the sum of the number of patients expected to remain in the program from prior years, and the number of new patients who may enter the program each year.

Family Planning Table 12 shows the anticipated caseload of organized programs by the number of new and continuing patients expected to be served in each year. In FY 1971, nearly 800,000 new patients were enrolled and the partial service statistics available for FY 1972 suggest that the number of new enrollees in that year may well have exceeded the 838,000 called for in the projection.

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FAMILY PLANNING TABLE 11

**ESTIMATES OF LOW-INCOME INDIVIDUALS EXPECTED TO RECEIVE
FAMILY PLANNING SERVICES, FY 1972-1975**

<u>Year</u>	<u>Estimates of Individuals to Receive Family Planning Services</u>		
	<u>In Organized</u>	<u>By Private</u>	<u>Total</u>
	<u>Programs</u>	<u>Physicians</u>	
FY 1972	1,959,000	1,237,000	3,196,000
FY 1973	2,666,000	1,326,000	3,992,000
FY 1974	3,628,000	1,482,000	5,111,000
FY 1975	4,936,000	1,646,000	6,582,000

FAMILY PLANNING TABLE 12

**PROJECTION OF LOW-INCOME INDIVIDUALS
TO BE SERVED BY ORGANIZED PROGRAMS, FY 1972-75**

<u>Year</u>	<u>Individuals Served</u>			<u>Active Par- ticipants at End of Period</u>
	<u>Total</u>	<u>New</u>	<u>Continuing</u>	
FY 1972	1,959,000	838,000	1,121,000	1,716,000
FY 1973	2,666,000	1,049,000	1,617,000	2,378,000
FY 1974	3,628,000	1,377,000	2,251,000	3,293,000
FY 1975	4,936,000	1,797,000	3,139,000	4,556,000

The projected caseload of organized programs in FY 1975--4,936,000 patients--is lower by nearly 300,000 than was projected in the first Five-Year Plan. This is due to the increased proportion of women expected to be served by private physicians.

The number of patient visits and clinic sessions was projected by estimating the number of patients selecting the different methods of contraception, and the physicians' time required for these patients. The total number of visits expected for each year is:

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<u>Fiscal Year</u>	<u>Total Visits</u>
1973	4.5 million
1974	6.2 million
1975	8.7 million

Physician time required for each patient visit was estimated to be 10 minutes. Assuming two-hour weekly clinic sessions, the number of sessions projected for each year range from 7,200 in FY 1973 to 14,300 in FY 1975.

The number of clinic sessions projected for FY 1975 in this report is 400 less than in the original Five-Year Plan, primarily because of the estimate that private physicians will serve 285,000 more patients than originally anticipated.

In order to estimate current manpower and to project manpower needed by 1975, a staffing module for each two-hour clinic session was developed. This staffing pattern was based on data from current programs and recent studies, and assumed the following ratio of other clinic staff per physician:

Ratio of Other Clinic Staff per Physician

Physician	1
Nurse	1
Aides	2

Outreach workers (calculated in terms of hours per patient):

Patients in Metropolitan Areas	1
Patients in Nonmetropolitan Areas	2

Family Planning Table 13 uses this ratio to estimate the personnel employed in the provision of family planning services in FY 1972.

Estimates of the number of individual physicians employed in the program ranged from 3,900 to 5,000. Nurses were estimated at 1,650, aides and clerks at 3,300, and outreach workers at 4,000.

FAMILY PLANNING TABLE 13
ESTIMATED NUMBER OF PHYSICIANS, NURSES, AIDES AND OUTREACH WORKERS
EMPLOYED IN FAMILY PLANNING PROGRAMS, FY 1972

Area and Proportion of Patient Load	Weekly Clinic Sessions Estimated	Hours Per Week (2 Sessions) Estimated	Physicians				Other Staff:		Nurses	
			Estimated Number Employed If Each Session Is Manned By a Different Physician	If 25% of Sessions are Manned by Full-Time Physicians	Total Hours	Total Time (32 Hours)	Full- Time (32 Hours)	Part- Time (8 Hours)	Hours Per Week (4 Hours Per Session)	Estimated Number Employed
Total	5,000	10,000	5,000	156	3,750	3,906	--	--	20,000	281
Metropolitan Area (80%)	4,000	8,000	4,000	125	3,000	3,125	50%	50%	16,000	250
Nonmetropolitan Area (20%)	1,000	2,000	1,000	31	750	781	25%	75%	4,000	31
										1,375
										1,656
										1,250
										406
										375
										406

Hours Per Week (4 Hours Per Session)	Aides and Clerks		Hours Per Week		Outreach Workers	
	Estimated Number Employed		1 Hr. Per Yr.		Estimated Number Employed	
	Full- Time	Part- Time	Estimated Patients (000's)	Per Metropolitan Patient, 2 Per Nonmetropolitan	Full- Time	Part- Time
40,000	562	2,750	3,312	1,959	612	3,429
32,000	500	2,000	2,500	1,567	489	1,959
8,000	62	750	812	392	123	1,470
						1,593

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Using the same staffing ratio, the manpower required in FY 1975 to serve 4,936,000 patients in organized programs is estimated in Family Planning Table 14.

Future Manpower Resources for Family Planning

The largest gaps in manpower appear to be among physicians, aides, and outreach workers, particularly in nonmetropolitan areas. The supply of nurses appears to be adequate if part-time positions can be created for currently inactive nurses. Many of these inactive nurses have not had training in public health nursing and may require special training, particularly for supervisory roles in rural areas.

The shortage of physicians in nonmetropolitan areas may present a barrier to provision of services in the remaining counties with low population density and no reported family planning services. The available data suggest a need for about 4,000 additional physicians in nonmetropolitan areas by FY 1975. An alternative approach may be to utilize specially trained nurse-practitioners or other physician-equivalents under medical supervision to provide medical services in uncomplicated cases. This pattern is reported by a growing number of family planning programs.

Clinic and Agency Administrative Requirements

At the provider agency level, about 1,000 full-time clinic supervisors will be required in FY 1975 in metropolitan areas and 1,875 (375 full-time and 1,500 part-time) in nonmetropolitan areas. At least 400 full-time agency administrators will be needed by FY 1975.

Private Physician Programs

In addition to the 4,936,000 low-income patients to be served in FY 1975 by organized programs, another 1,646,000 patients will be served by private physicians. The number of private physicians required is estimated at about 16,500.

Summary of Manpower Requirements, FY 1975

Family Planning Table 15 presents a summary of manpower estimated to be needed by FY 1975. The number of staff in all categories is estimated at 58,000. Approximately 27,000 would be physicians, most of whom are expected to devote only a few hours a week to family planning activities. Also, 31,000 nurses, aides, outreach workers, and administrators will be required, most of whom will only be employed part-time in family planning activities.

These estimates are based on very fragmentary information about current staffing patterns and can only be regarded as suggestive of the numbers and types of manpower needed. The estimate for outreach may not prove realistic, particularly because emphasis appears to be shifting away from recruitment in some programs. Some of the communication about contraception for which outreach workers are especially trained and qualified is also now publicized in the media.

FAMILY PLANNING TABLE 15

SUMMARY OF ESTIMATED MANPOWER REQUIREMENTS FOR U.S. FAMILY PLANNING PROGRAM, BY TYPE OF PERSONNEL AND FULL OR PART-TIME STATUS, FY 1975

Type of Personnel	<u>Organized Clinic Program</u>		<u>Private Physicians</u>	Total
	<u>Full-Time</u>	<u>Part-Time</u>	<u>Part-Time</u>	
Physicians	434	10,418	16,500	27,352
Nurses	681	4,221	...	4,902
Clerks/Aides	1,362	8,443	...	9,805
Outreach/ Follow-up Staff	1,542	11,477	...	13,019
Administrators	1,775	1,500	...	3,275
(Clinic)	(1,375)	(1,500)	...	(2,875)
(Agency)	(400)	(400)
Total	5,794	36,059	16,500	58,353
Total Excluding Physicians	5,360	25,641	...	31,001

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**VI. Progress Report of Family Planning Services Programs,
Department of Health, Education, and Welfare**

A. National Summary

The Health Services and Mental Health Administration (HSMHA) is the major source of Federal Government support for subsidized family planning services in the United States. It contains several organizational components which are responsible for family planning activities. The two major components are the National Center for Family Planning Services (NCFPS) and the Maternal and Child Health Service (MCHS). In addition, family planning activities are carried out by the Community Health Service, the Federal Health Programs Service, the Indian Health Service, the National Center for Health Statistics, the National Center for Health Services Research and Development, and the National Institute of Mental Health.

Other Federal efforts have included family planning development and demonstration projects supported by the Office of Economic Opportunity (OEO). These OEO projects are now being transferred to the NCFPS. The Department of Housing and Urban Development funds family planning activities through its Model Cities Program in conjunction with NCFPS funded projects.

The National Center for Family Planning Services project grants program has grown markedly from 80 grants and \$12 million of obligations at its inception in fiscal year 1969 to 300 grants and \$98.5 million of obligations in fiscal year 1973. During this time, about 250 OEO projects with operating costs of \$20 million have been transferred to NCFPS and the remaining 200 OEO projects and funds will be transferred to NCFPS in FY 1974. To improve program coordination many of these projects, as well as ongoing NCFPS projects, have been consolidated into areawide or Statewide grants. Over 200 grants have been consolidated, holding the total number of grants to about 300, rather than a much larger number which would exist otherwise. The Center will continue to encourage grant consolidations which improve services and reduce administrative costs.

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Progress has been measured in this Report by two variables:

1. County coverage (Family Planning Tables 16 and 17).
2. Capacity to provide services (Family Planning Tables 18-19).

The first measure, county coverage, presented in this Report is based on a Regional program review conducted in each Regional Office during the first months of fiscal year 1973. The data for each Region was reviewed by the appropriate NCFPS Regional Program Director and adjusted to reconcile the findings with existing Regional information. Family Planning Tables 16 and 17 show the number of counties with services available by each Region and by each State within the Region.

The 2,379 counties with services available contain over 90 percent of the women needing subsidized services, and the 720 counties shown to be without services available are mainly rural and contain less than 10 percent of the women estimated to need subsidized services.

Capacity

The second measure of program accomplishment is the extent that capacity has been established to provide subsidized family planning services. The capacity of organized programs is estimated as the number of women who can be served with available funds. Funds used to compute capacity include those funds identified by Regional Family Planning Directors shown in Family Planning Tables 18 and 19. Funds include Federal, State and local, and private sources.

Capacity for FY 1973 is based on the average cost per patient, derived from financial reports of family planning projects and patient counts. It is obtained by dividing funds available by the average FY 1972 cost per patient. Capacity estimates are approximations since many providers pro-rate costs for family planning services--one of many health and social services they offer, and patient loads are difficult to measure accurately.

Family Planning Tables 18 and 19 show estimates of organized programs capacity for June 30, 1972 and 1973. These estimates are based on average patient costs from individual States and not on a single national average.

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FAMILY PLANNING TABLE 16

GEOGRAPHIC COVERAGE FOR EACH REGION AND U.S.
AS OF JUNE 30, 1971 AND JUNE 30, 1972

U.S. and Region	Number of Counties	Counties With Organized Services <u>Available*</u>		Change FY 1972	Counties Without Organized Services Available 6/30/72
		6/30/71	6/30/72		
U.S. Total	3,099	2,039	2,379	340	720
Region:					
I	67	34	48	14	19
II	83	51	67	16	16
III	247	172	209	37	38
IV	735	711	714	3	21
V	523	263	331	68	192
VI	502	323	416	93	86
VII	411	260	271	11	140
VIII	291	123	171	48	120
IX	93	64	74	10	19
X	147	38	78	40	69

*Includes counties which use service facilities located in adjacent counties.

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FAMILY PLANNING TABLE 17

GEOGRAPHIC COVERAGE BY COUNTY, FOR EACH REGION AND STATE
AS OF JUNE 30, 1971 AND JUNE 30, 1972

Region or State	Number of Counties	Counties With Organized Services Available		Change FY 1972	Counties Without Organized Services Available 6-30-72
		6-30-71	6-30-72		
Region I Total	67	34	48	14	19
Massachusetts	14	4	7	3	7
Connecticut	8	4	6	2	2
Maine	16	10	13	3	3
Rhode Island	5	1	5	4	0
New Hampshire	10	8	8	0	2
Vermont	14	7	9	2	5
Region II Total	83	51	67	16	16
New York	62	37	51	14	11
New Jersey	21	14	16	2	5
Puerto Rico	---	---	---	---	---
Virgin Islands	---	---	---	---	---
Region III Total	247	172	209	37	38
Pennsylvania	67	25	39	14	28
Virginia	98	87	94	7	4
West Virginia	55	33	49	16	6
Maryland	23	23	23	0	0
District of Columbia	1	1	1	0	0
Delaware	3	3	3	0	0
Region IV Total	736	711	714	3	22
North Carolina	100	93	94	1	6
Florida	67	67	67	0	0
Georgia	159	158	158	0	1
Tennessee	95	95	95	0	0
Alabama	67	67	67	0	0
Kentucky	120	104	105	1	15
Mississippi	82	81	82	1	0
South Carolina	46	46	46	0	0

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Region or State	Number of Counties	Counties With Organized Services Available		Change FY 1972	Counties Without Organized Services Available 6-30-72
		6-30-71	6-30-72		
Region V Total	523	263	331	68	192
Ohio	88	43	69	26	19
Illinois	102	12	37	25	65
Michigan	83	75	77	2	6
Indiana	92	28	43	15	49
Minnesota	87	69	69	0	18
Wisconsin	71	36	36	0	35
Region VI Total	502	323	416	93	86
Texas	254	122	182	60	72
Louisiana	64	64	64	0	0
Arkansas	75	49	75	26	0
Oklahoma	77	61	65	4	12
New Mexico	32	27	30	3	2
Region VII Total	411	260	271	11	140
Missouri	114	69	77	8	37
Iowa	99	63	63	0	36
Kansas	105	68	70	2	35
Nebraska	93	60	61	1	32
Region VIII Total	292	123	172	49	120
Colorado	63	31	44	13	19
South Dakota	67	44	46	2	21
Utah	29	29	29	0	0
North Dakota	53	8	26	18	27
Montana	56	5	16	11	40
Wyoming	24	6	11	5	13
Region IX Total	93	64	74	10	19
California	58	45	53	8	5
Arizona	14	10	12	2	2
Nevada	17	5	5	0	12
Hawaii	4	4	4	0	0
Guam	---	---	---	---	---
Region X Total	147	38	78	40	69
Washington	39	5	28	23	11
Oregon	36	16	21	5	15
Idaho	44	8	19	11	25
Alaska (Legislative Districts)	28	9	10	1	18

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FAMILY PLANNING TABLE 18
ESTIMATED SERVICE CAPACITY

U.S. and Region	Estimated Service Capacity Available 6/30/72	Estimated Service Capacity Available 6/30/73
U.S. Total	2,740,000	2,981,000
Region:		
IV	632,000	643,000
V	429,000	484,000
VI	387,000	406,000
III	196,000	200,000
II	223,000	286,000
IX	505,000	545,000
VII	163,000	167,000
I	63,000	66,000
VIII	60,000	74,000
X	82,000	110,000

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FAMILY PLANNING TABLE 19
ESTIMATED SERVICE CAPACITY

Region or State	Estimated Service Capacity Available 6-30-72	Estimated Service Capacity Available 6-30-73
Region IV Total	632,000	543,000
North Carolina	67,000	66,000
Florida	153,000	150,000
Georgia	94,000	102,000
Tennessee	72,000	73,000
Alabama	51,000	55,000
Kentucky	77,000	84,000
Mississippi	41,000	41,000
South Carolina	77,000	72,000
Region V Total	429,000	484,000
Ohio	79,000	81,000
Illinois	129,000	136,000
Michigan	126,000	123,000
Indiana	37,000	45,000
Minnesota	47,000	77,000
Wisconsin	11,000	22,000
Region VI Total	387,000	406,000
Texas	180,000	185,000
Louisiana	94,000	107,000
Arkansas	36,000	37,000
Oklahoma	54,000	54,000
New Mexico	23,000	23,000
Region III Total	196,000	200,000
Pennsylvania	93,000	92,000
Virginia	27,000	29,000
West Virginia	15,000	16,000
Maryland	48,000	51,000
District of Columbia	6,000	5,000
Delaware	7,000	7,000
Region II Total	223,000	286,000
New York	164,000	214,000
New Jersey	59,000	72,000
Puerto Rico*	58,000	68,000
Virgin Islands*	7,000	7,000

Region or State	Estimated Service Capacity Available 6-30-72	Estimated Service Capacity Available 6-30-73
Region IX Total	505,000	545,000
California	418,000	451,000
Arizona	54,000	55,000
Hawaii	14,000	14,000
Nevada	19,000	19,000
Guam*	4,000	6,000
Region VII Total	163,000	167,000
Missouri	77,000	77,000
Iowa	27,000	30,000
Kansas	36,000	37,000
Nebraska	23,000	23,000
Region I Total	63,000	65,000
Massachusetts	30,000	32,000
Connecticut	9,000	9,000
Maine	6,000	8,000
Rhode Island	8,000	6,000
New Hampshire	4,000	4,000
Vermont	6,000	6,000
Region VIII Total	60,000	74,000
Colorado	31,000	37,000
South Dakota	4,000	6,000
Utah	6,000	6,000
North Dakota	5,000	7,000
Montana	11,000	15,000
Wyoming	3,000	3,000
Region X Total	82,000	110,000
Washington	44,000	67,000
Oregon	32,000	37,000
Idaho	4,000	4,000
Alaska	2,000	2,000

*Not included in totals.

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Funding

The DHEW Regional Program Directors, through the use of Federal grant records and discussions with State officials and local project directors, projected the funds expected to be available in fiscal year 1973 by Federal and non-Federal sources. Family Planning Table 20 presents a summation of funding figures for each Region, and Family Planning Table 21 presents funding information for each State. The Federal Government has been the source of over 75 percent of the funds identified as available to organized subsidized programs in FY 1973. The funds shown here do not include substantial sums supplied by the Social and Rehabilitation Service as third-party payments for the Medicaid program through which patients obtain family planning services through private physicians not usually associated with organized programs.

FAMILY PLANNING TABLE 20

ESTIMATED FUNDING FOR ORGANIZED PROGRAMS, FY 1973
(In Thousands of Dollars)

<u>Region</u>	<u>Total</u>	<u>Federal</u>	<u>Non-Federal</u>
Total	\$186,558	\$144,590	\$41,968
IV	38,218	29,377	8,841
V	26,267	17,390	8,877
VI	31,407	24,174	7,233
III	13,890	11,774	2,116
II	28,708	23,065	5,643
IX	24,562	19,724	4,838
VII	8,721	7,199	1,522
I	5,923	4,791	1,132
VIII	4,115	3,596	519
X	4,747	3,500	1,247

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FAMILY PLANNING TABLE 21

ESTIMATED FUNDING FROM FEDERAL AND NON-FEDERAL SOURCES, FY 1973
(In thousands of Dollars)

Region or State	Total	Federal	Non-Federal
Region IV Total	\$38,218	\$29,377	\$8,841
North Carolina	3,952	2,933	1,019
Florida	9,001	7,375	1,626
Georgia	6,093	4,727	1,366
Tennessee	4,354	3,332	1,022
Alabama	3,293	2,558	735
Kentucky	4,700	3,473	1,227
Mississippi	2,506	1,892	614
South Carolina	4,319	3,087	1,232
Region V Total	\$26,267	\$17,390	\$8,877
Ohio	8,247	4,147	4,100
Illinois	6,584	4,392	2,192
Michigan	4,498	3,323	1,175
Indiana	2,789	2,289	500
Minnesota	1,994	1,669	325
Wisconsin	2,155	1,570	585
Region VI Total	\$31,407	\$24,174	\$7,233
Texas	11,929	8,967	2,962
Louisiana	11,827	9,098	2,729
Arkansas	2,686	2,209	477
Oklahoma	3,484	2,591	893
New Mexico	1,481	1,309	172
Region III Total	\$13,890	\$11,774	\$2,116
Pennsylvania	6,000	5,270	730
Virginia	1,748	1,513	235
West Virginia	1,327	1,225	102
Maryland	3,170	2,538	632
Delaware	468	365	103
District of Columbia	1,177	863	314
Region II Total	\$28,708	\$23,065	\$5,643
New York	17,305	14,921	2,384
New Jersey	5,609	4,553	1,056
Puerto Rico	5,396	3,269	2,127
Virgin Islands	398	322	76

Region or State	Total	Federal	Non-Federal
Region IX Total	\$24,562	\$19,724	\$4,838
California	21,196	17,093	4,103
Arizona	1,862	1,461	401
Hawaii	844	669	175
Nevada	445	345	99
Guam	215	155	60
Region VII Total	\$8,721	\$7,199	\$1,522
Missouri	4,962	3,958	1,004
Iowa	1,357	1,189	168
Kansas	1,078	907	171
Nebraska	1,324	1,145	179
Region I Total	\$5,862	\$4,731	\$1,131
Massachusetts	2,618	2,131	487
Connecticut	906	733	173
Maine	1,043	822	161
Rhode Island	206	139	67
New Hampshire	600	492	107
Vermont	550	414	136
Region VIII Total	\$4,116	\$3,597	\$519
Colorado	1,585	1,236	349
South Dakota	476	430	46
Utah	585	581	4
North Dakota	414	379	35
Montana	821	756	65
Wyoming	235	215	20
Region X Total	\$4,747	\$3,500	\$1,247
Washington	2,357	1,633	724
Oregon	1,806	1,357	449
Idaho	359	325	34
Alaska	225	175	50

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Early in FY 1973, each family planning Regional Program Director was asked to determine the current status of family planning services in his Region. As one part of that task, current providers were asked to indicate the reasons their programs had grown. Health agencies which were not providers of family planning services were asked about their interests in providing services. Details of the survey results are shown in Family Planning Tables 22 and 23.

Information based on contact with 1,653 current providers and 1,217 potential providers showed the following:

1. Nearly all current provider agencies served more patients in fiscal year 1972 than in fiscal year 1971 and more than one-third of current providers expected their programs to continue growing in fiscal year 1973.
2. The reasons most often mentioned for growth were increased demand for services and sufficient funds, followed by establishment of more clinics and/or services and initiation of public relations, educational or outreach programs.
3. Almost half of the potential providers--some 566 agencies--were interested in having a subsidized program for providing family planning services.

FAMILY PLANNING TABLE 22

PROGRAM GROWTH IN FY 1972 REPORTED
IN NCFPS STATUS REVIEW - CURRENT PROVIDERS

Type of Agency	Total Agencies	Program Grew in FY 1972				Percent Distribution by Reason Grew							
		Yes		No		Total	Demand	Funds	Manpower	Policy	Other	Unknown	
		Number	Per-cent	Number	Per-cent								
Total	1653	1514	91.6	139	8.4	100.0	45.2	11.8	4.2	10.0	27.6	1.1	
Hospital	439	374	85.2	65	14.8	100.0	48.9	6.4	2.9	7.0	32.4	2.4	
Health Dept.	711	661	93.0	50	7.0	100.0	47.4	16.5	5.6	5.3	24.5	.8	
Planned Parenthood	123	117	95.1	6	4.9	100.0	49.6	10.3	2.6	9.4	27.4	.9	
Other	380	362	95.3	18	4.7	100.0	36.2	9.1	3.6	22.1	28.5	.6	

FAMILY PLANNING TABLE 23
NCFPS STATUS REVIEW - POTENTIAL PROVIDERS

Type of Agency	Total Agencies	Interested in Providing Family Planning Services				Not Interested in Providing Family Planning Services				Percent Distribution by Reasons Not Interested									
		Num-	Per-	Num-	Per-	Num-	Per-	Num-	Per-										
		ber	cent	ber	cent	ber	cent	ber	cent	Total	Demand	Funds	No Manpower	Agency Policy	Don't Serve Low-Income Families	No Out-Patient Department	Other		
Total	1217	566	46.5	651	53.5	100.0	11.3	38.0	16.8	2.7	31.3	100.0	23.5	3.1	8.1	11.2	2.8	4.6	46.7
Hospital	926	415	44.8	511	55.2	100.0	12.0	34.2	15.7	2.4	35.7	100.0	23.7	2.7	8.4	12.9	3.3	4.9	44.0
Health Dept.	276	141	51.1	135	48.9	100.0	9.2	47.5	20.6	3.5	19.1	100.0	23.0	4.4	6.7	5.2	0.7	3.0	57.0
Other	15	10	66.7	5	33.3	100.0	10.0	60.0	10.0	0.0	20.0	100.0	20.0	0.0	20.0	0.0	0.0	20.0	40.0

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CostsServices

During the past year the Westinghouse Population Center conducted a cost study of a sample of NCFPS grantees.¹ The average patient costs varied widely by project with an average of \$66 per patient (Family Planning Table 24). The major determinant of cost in the sample program was the age of the program. Programs which began before 1968 had lower costs. Program size also affected the cost per patient; large programs had lower costs per patient than the small programs. Medium size programs had the lowest costs. As programs reach their planned patient loads, costs are expected to decrease.

FAMILY PLANNING TABLE 24

RANGE OF ESTIMATED COSTS FOR DELIVERY OF SERVICES,
FY 1972 - 1975
(in millions of dollars)

Type of Delivery	FY 1972	FY 1973	FY 1974	FY 1975
Organized Programs	113-129	157-175	207-229	273-296
Private Physicians	74- 82	80- 88	85- 93	92- 99
Total	187-211	237-263	293-322	360-395

Total Costs

Family Planning Table 25 summarizes the fiscal years 1972-1975 projection of estimated total costs, including delivery of services; manpower development; operational research; planning and evaluation; and information and education.

¹Westinghouse Population Center, Comprehensive Report: Cost Study of A Sample of the Grantees of the NCFPS, HSM 110-71-219, Columbia, Maryland, 1972.

Range of Estimated Costs for Subsidized Family Planning Services
in the United States, Fiscal Years 1972 - 1975
(in millions of dollars)

Program Components	FY 1972	FY 1973	FY 1974	FY 1975
Delivery of Services	187 - 211	237 - 263	293 - 322	365 - 395
Organized Programs	(113 - 129)	(157 - 175)	(207 - 229)	(273 - 296)
Private Physicians	(74 - 82)	(80 - 88)	(86 - 93)	(92 - 99)
Manpower Development	4 - 6	5 - 8	6 - 10	8 - 12
Clinic Level Personnel	(3 - 5)	(3 - 6)	(4 - 7)	(5 - 9)
Coordinating Staffs	(1 - 1)	(2 - 2)	(2 - 3)	(3 - 3)
Operational Research, Planning and Evaluation	4 - 6	5 - 7	8 - 12	9 - 15
Information and Education**	3 - 4	4 - 5	6 - 8	10 - 12
Total	198 - 227	251 - 283	313 - 352	392 - 434

*Federal agencies and other national institutions, organizations, and industries in the United States combined.

**Also includes population education activities authorized under P.L. 91-516 and Section 1005 of P.L. 91-572.

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In fiscal year 1975, an estimated \$392-434 million will be required to finance activities to provide subsidized family planning services for the women estimated to need subsidized services. This estimate includes funds from State, local, and private sources, as well as Federal funds, and third-party payment programs such as Medicaid funds to pay for services.

The Maternal and Child Health Service (MCHS) administers family planning programs under Title V of the Social Security Act. It administers programs of formula grants to States, comprehensive maternity and infant care projects, and related research grants.

The 1973 budget for maternal and child health activities under Title V of the Social Security Act anticipates obligations of \$16.2 million for family planning services. This amount includes \$11.7 million in the Maternal and Child Health Service formula grant programs and \$4.5 million for 54 Maternity and Infant Care Projects for high-risk prospective mothers which include family planning services. Patients served by grants from MCHS as reported by the States are shown in Family Planning Tables 26-28. The figures in Family Planning Table 28 show an apparent decline from 1971 to 1972 in total M & I patients served. This apparent decline occurred because of revised reporting procedures. Patients in M & I projects which are funded by both the National Center for Family Planning Services and MCHS are no longer included in M & I reports. They are now included only in NCFPS reports.

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FAMILY PLANNING TABLE 26

Number of Women Provided Family Planning Services Under State Programs
Of Maternal and Child Health, FY 1972, 1971, and 1970

State	1972 Provisional	1971	1970	
United States	866,711	763,234	501,795	
Alabama	62,528	50,669	45,571	
Alaska	1/ 733	892	733	
Arizona	25,629	11,804	7,707	
Arkansas	19,114	15,066	7,066	
California	1/ 121,074	93,931	66,522	
Colorado	4,721	1,242	2,215	
Connecticut	---	---	---	
Delaware	7,440	5,676	9,465	
Dist. Columbia	---	---	---	
Florida	98,077	67,704	57,554	
Georgia	88,628	75,799	51,018	
Guam	---	---	---	
Hawaii	390	---	---	
Idaho	1,746	920	383	
Illinois	1/ 6,623	5,097	1,315	
Indiana	10,525	5,127	3,476	
Iowa	---	---	---	
Kansas	1/ 11,870	1/ 8,300	1/ 11,870	
Kentucky	11,215	1/ 17,170	11,255	
Louisiana	---	---	---	
Maine	12,000	3,900	---	
Maryland	---	4,816	---	
Massachusetts	---	---	---	
Michigan	1/ 3,040	1/ 9,654	3,040	
Minnesota	---	1/ 1,300	6,057	
Mississippi	30,156	22,095	15,586	
Missouri	1/ 25,287	25,166	25,287	
Montana	---	1,893	356	
Nebraska	188	---	1/ 7,850	
Nevada	1,469	2,726	---	
New Hampshire	---	---	---	
New Jersey	---	---	---	
New Mexico	---	3,260	4,568	
New York	1/ 5,165	10,034	5,165	
North Carolina	68,644	35,081	28,931	
North Dakota	---	549	---	
Ohio	---	62,944	---	
Oklahoma	---	17,645	---	
Oregon	28,079	6,275	2,696	
Pennsylvania	---	---	---	
Puerto Rico	---	---	---	
Rhode Island	4,254	---	---	
South Carolina	32,556	---	17,165	
South Dakota	1/ 140	---	140	
Tennessee	23,233	22,486	27,031	
Texas	47,065	32,131	28,424	
Utah	1/ 693	963	693	
Vermont	---	---	---	
Virgin Islands	---	---	1,625	Code: 1/ Estimated
Virginia	1/ 42,000	51,529	42,103	
Washington	5,720	11,680	6,000	Zero
West Virginia	8,443	6,496	2,859	Data not
Wisconsin	1,633	---	---	available
Wyoming	265	315	129	

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FAMILY PLANNING TABLE 27

Number of Women Provided Family Planning Services
Under State Programs of Maternal and Child Health
Fiscal Year 1972 - Provisional

STATE	Total	New	Carried over from last year		
United States	866,711	342,700	346,245		
Alabama	62,528	43,842	18,686		
Alaska	E 733	---	---		
Arizona	25,629	12,061	13,568		
Arkansas	19,114	8,310	10,804		
California	E 121,074	48,355	72,719		
Colorado	4,721	---	---		
Connecticut	---	---	---		
Delaware	7,440	4,364	3,076		
Dist. Columbia	---	---	---		
Florida	98,077	50,117	47,960		
Georgia	88,628	44,798	43,830		
Guam	---	---	---		
Hawaii	390	390	---		
Idaho	1,746	818	928		
Illinois	E 6,522	---	---		
Indiana	10,522	---	---		
Iowa	---	---	---		
Kansas	E 11,870	---	---		
Kentucky	11,215	---	---		
Louisiana	---	---	---		
Maine	12,000	---	---		
Maryland	---	---	---		
Massachusetts	---	---	---		
Michigan	E 1,040	---	---		
Minnesota	---	---	---		
Mississippi	30,156	16,024	14,132		
Missouri	E 25,287	---	---		
Montana	---	---	---		
Nebraska	189	---	---		
Nevada	1,469	---	---		
New Hampshire	---	---	---		
New Jersey	---	---	---		
New Mexico	---	---	---		
New York	E 5,165	---	---		
North Carolina	48,674	23,064	24,700		
North Dakota	---	---	---		
Ohio	---	---	---		
Oklahoma	---	---	---		
Oregon	28,979	---	---		
Pennsylvania	---	---	---		
Puerto Rico	---	---	---		
Rhode Island	4,754	---	---		
South Carolina	32,554	15,519	17,035		
South Dakota	E 140	---	---		
Tennessee	98,777	43,204	55,573		
Texas	47,007	26,751	20,344		
Utah	E 693	---	---		
Vermont	---	---	---		
Virginia	---	---	---		
Washington	5,720	2,299	3,420		
West Virginia	8,000	---	---		
Wisconsin	1,613	1,616	17		
Wyoming	761	160	85		

E = estimated

- = none

--- = not available

FAMILY PLANNING TABLE 28

Maternity and Infant Care Projects New Family Planning Admissions,
by State, for Fiscal Years 1970, 1971, and 1972

STATE	1972 (provisional)	1971	1970		
United States	120,284	134,684	109,742		
Alabama	4,497	2,998	2,971		
Alaska	-	-	-		
Arizona	-	-	-		
Arkansas	2,233	2,316	1,707		
California	249	27	205		
Colorado	4,558	4,713	3,510		
Connecticut	1,091	1,150	1,022		
Delaware	-	-	-		
Dist. Columbia	7,855	5,615	6,530		
Florida	15,637	12,130	11,257		
Georgia	16,405	14,631	10,560		
Guam	-	-	-		
Hawaii	501	427	421		
Idaho	146	157	97		
Illinois	6,173	18,474	13,410		
Indiana	13	-	-		
Iowa	-	-	-		
Kansas	-	-	-		
Kentucky	558	552	616		
Louisiana	-	-	-		
Maine	6	0	178		
Maryland	2,076	6,939	4,094		
Massachusetts	3,031	3,129	2,164		
Michigan	3,319	2,058	3,333		
Minnesota	827	1,747	1,375		
Mississippi	649	815	657		
Missouri	2,555	2,412	2,041		
Montana	-	-	-		
Nebraska	1,592	1,355	957		
Nevada	-	-	-		
New Hampshire	-	-	-		
New Jersey	449	622	575		
New Mexico	1,048	920	350		
New York	14,019	19,143	18,255		
North Carolina	1,330	1,187	677		
North Dakota	-	-	-		
Ohio	5,146	5,453	2,752		
Oklahoma	-	-	-		
Oregon	462	338	377		
Pennsylvania	4,356	4,219	3,275		
Puerto Rico	1,058	2,122	1,011		
Rhode Island	691	464	377		
South Carolina	2,072	2,403	2,125		
South Dakota	-	-	-		
Tennessee	-	-	-		
Texas	9,531	10,307	8,473		
Utah	-	-	-		
Vermont	-	-	-		
Virgin Islands	-	-	-		
Virginia	1,020	1,245	1,015		
Washington	1,526	1,501	825		
West Virginia	1,553	1,536	1,411		
Wisconsin	-	-	-		

The Social and Rehabilitation Service (SRS), through the Community Services Administration, the Medical Services Administration, and the Office of Planning, Research, and Training supports family planning services for low-income individuals. Particular target groups are those receiving "Aid to Families with Dependent Children" (AFDC) payments, and those eligible for medical assistance through Medicaid. These services promote health, reduce out-of-wedlock pregnancies, and enable State welfare agencies to carry out their responsibilities in work-training and employment programs for AFDC recipients. Included in these services are targeted programs of research and demonstration projects in family planning.

The Social Security Amendments of 1967 (P.L. 90-248) and 1972 (P.L. 92-603) include the authority to provide family planning services to those individuals desiring such services, including medical contraceptive services (diagnosis, treatment, supplies, and follow-up), social services and educational services. Such services must be available without regard to marital status, age, or parenthood. Individuals must be assured choice of method, and there must be arrangements with varied medical resources. Acceptance of any service must be voluntary and may not be a prerequisite or impediment to eligibility for the receipt of any other service or financial aid. Medical services must be provided in accordance with the standards of other State programs providing medical services for family planning, such as maternal and child health services.

States are required to report the results of implementing the family planning provisions of the Social Security Act as amended, to the Secretary. The Secretary is required to make similar annual reports to the Congress.

The Social Security Amendments of 1972 provide significant new incentives for the provision of family planning services. Prior to the passage of these Amendments, the provision of family planning services was a State option. However, PL 92-603 makes the informing of the availability and the provision of family planning services mandatory to all present and to certain former or potential recipients of AFDC who are of childbearing age. The Act imposes a penalty of one percent per annum on the Federal share of AFDC funds on States which failed to provide these services in the previous year to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Title IV-A -- AFDC -- to 90 percent from 75 percent and increases the Federal share for family planning services under Title XIX -- Medicaid -- to 90 percent from a variable formula with a range from 50 to 83 percent Federal matching.

The 1968 Amendments to the Vocational Rehabilitation Act (PL 90-391) provide for services to family members when this will contribute to the rehabilitation of the handicapped individual. Therefore, the Rehabilitation Services Administration may arrange for family planning services for handicapped individuals and their families as a part of the client's overall rehabilitation plan when such services can "substantially" improve the successful rehabilitation of the client.

Community Services Administration

The Community Services Administration, SRS, assists States in developing plans and administering programs for family planning services. All States and jurisdictions, with one exception, have fulfilled the Title IV-A requirements of the 1967 Amendments to the Social Security Act to provide for the offering of family planning services in all appropriate cases and to assure that acceptance of family planning services is voluntary.

Family planning services include the provision of information, personal counseling, medical services, payment for medical services, referral for medical care, follow-up of medical referrals, provision for transportation and child care arrangements so that parents may obtain medical care, and the development of medical resources when none exist.

The 1972 Amendments to the Social Security Act, PL 92-603, make the informing of the availability and the provision of family planning services mandatory to all present and to certain former or potential recipients of AFDC who are of childbearing age and impose a penalty of one percent per annum on the Federal share of AFDC funds on States which failed to provide these services in the previous year to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Title IV-A -- AFDC -- to 90 percent from 75 percent. The Act expands the universe of persons to whom family planning services are offered since it includes applicants for, as well as recipients of, public assistance and adds a statement on sexually active minors.

A program directed to sexually active minors will reach young males as well as females. Counseling and information about family planning and family planning methods will be available to assist adolescents in making decisions which will enable them to continue their development without the burden of very early parenthood.

The subject of medical services to minors will receive continuing attention from the Community Services Administration. Due to State laws, medical standards prevailing in a State and its localities, and the attitudes of individual medical practitioners, medical services may not be available to minors without the consent of their parents. A few States permit medical care without parental permission when referrals for family planning medical resources are made by persons specifically designated in State legislation. Other States are contemplating such changes in their laws. The Community Services Administration will determine how minors may secure family planning assistance consistent with attitudes of the public regarding parental involvement.

State and local agencies have been working to develop cooperative relationships with public and private providers of medical services. The emphasis in the 1972 Amendments to the Social Security Act on the immediate provision of family planning services to those desiring them should assure continuation of efforts to develop additional medical resources.

The estimated numbers of families receiving family planning services through the AFDC social services program and adult social service programs during fiscal years 1972 through 1974 are indicated in Family Planning Table 29. Funding for Title IV-A is shown in Family Planning Table 30.

FAMILY PLANNING TABLE 29
Estimates of Families Receiving Family Planning Services*
Through the AFDC Social Services Program
and Adult Social Service Programs, FY 1972 - 1974

	<u>FY 1970</u>	<u>FY 1971</u>	<u>FY 1972</u>	<u>FY 1973</u>	<u>FY 1974</u>
Recipients	333,000	737,000	925,000	1,100,000	1,750,000

*These generally represent social rather than medical services.

Medical Services Administration

The Social Security Act of 1965 (PL 89-97--approved July 5, 1965) added Title XIX, "Grants to States for Medical Assistance" to the Social Security Act. Under the Federal-State medical assistance program which it established, known as Medicaid, States participating in the program were required to provide medical assistance to all recipients of cash assistance. At State option, they could also finance medical care for the medically needy, i.e., those persons who would otherwise be eligible for cash assistance except that the level of their income is sufficient to sustain themselves, but too low to provide necessary medical care. In addition, States could opt to provide coverage to children under 21 from low-income families.

Under the original legislation, inclusion of family planning services was a State option. However, PL 92-603, passed in October 1972, made coverage of family planning services for cash assistance recipients under Title XIX mandatory on the States. In addition, the rate of Federal financial participation for family planning services for both the categorically and medically needy was increased to 90 percent on the date of enactment of the Bill. The law also provides a penalty of a one percent reduction in the Federal share of AFDC funds if a State fails to (1) inform AFDC adults of the availability of family planning services or (2) fails to provide such services when requested. This provision becomes effective July 1, 1973.

Medical assistance for family planning includes payments for appropriate medical examinations, diagnosis, medical counseling and treatment, laboratory services, surgical procedures, drugs, supplies and devices. These services may be provided in doctor's offices, clinics, hospitals (on both an inpatient and outpatient basis), family planning center, or any other suitable setting.

Because of the increased responsibility placed on the State agencies to assure that family planning services are offered to all eligible persons who wish to utilize them, and because of the increased Federal matching, substantial increases are expected in Title XIX expenditures as shown in Family Planning Table 30.

FAMILY PLANNING TABLE 30
Title IV-A and Title XIX Expenditures
FY 1970 - 1974 (In Thousands)

	<u>Title IV-A</u>			<u>Title XIX</u>			<u>Total</u>
	<u>Federal</u>	<u>Local</u>	<u>Subtotal</u>	<u>Federal</u>	<u>Local</u>	<u>Subtotal</u>	
		<u>State</u>			<u>State</u>		
		<u>&</u>			<u>&</u>		
FY 1970	\$10,300	\$3,400	\$13,700	\$6,100	\$5,000	\$11,100	\$24,800
FY 1971	12,300	4,100	16,400	6,500	5,300	11,800	28,200
FY 1972	18,500	6,200	24,700	8,700	7,100	15,800	40,500
FY 1973*	21,400	4,500	25,900	22,400	4,200	26,600	52,500
FY 1974*	31,500	3,500	35,000	30,600	3,400	34,000	69,000

*Estimate

Estimates of the numbers of women receiving family planning services under Title XIX during fiscal years 1970 through 1974 are as indicated in Family Planning Table 31.

FAMILY PLANNING TABLE 31
Estimates of Women Receiving Family Planning
Services Under Title XIX, FY 1970 - 1974

	<u>Number of Women - Title XIX</u>
FY 1970	270,000
FY 1971	280,000
FY 1972	350,000
FY 1973	550,000
FY 1974	700,000

Office of Planning, Research and Training

The Office of Planning, Research, and Training, SRS, emphasizes family planning programs to demonstrate comprehensive services to families and individuals in model cities, neighborhood health centers, the center cities and rural poverty areas. Through in-service programs providing knowledge and skills needed by public welfare employees, a project has been developed to enable them to provide more effective family planning services to families and individuals.

Rehabilitation Services Administration

The Rehabilitation Services Administration, SRS, does not have a family planning program, per se. However, the Vocational Rehabilitation Amendments of 1968 authorize services to families of handicapped vocational rehabilitation clients when such services will contribute substantially to the rehabilitation of clients. Services to family members may also include homemaker services, day care services, foster family care services, and group counseling. Services to family members, however, are optional with the State rehabilitation agencies and are not mandatory under the current Vocational Rehabilitation Act and Federal regulations.

Under the current Developmental Disabilities Act, counseling services may include specialized family planning services where needed to DD clients and their families.

Overlap in Reporting Number of
Individuals Served in Organized Programs

The number of women served as measured by the various programs includes some overlap in reporting and some duplication in estimates. This occurs because most facilities providing subsidized family planning services are funded by multiple sources. For example many NCFPS grantees receive funds from State and local sources which are responsible for the operation of clinics in many locations. The diversity of funding sources and types of providers makes it inevitable that there be some duplication in reporting of individuals served. This is particularly true for formula grant programs, Medicaid, and social services programs.

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B. Program Development Strategy

There have been three major project grant authorities for family planning services. One, the oldest authority, is the Economic Opportunity Act, another is Title V of the Social Security Act (SSA), and the third is Title X of the Public Health Service (PHS) Act. The Administration plans to shift funding of the above family planning project grants to the Comprehensive Health Planning-Partnership for Health Act (Public Health Service Act, Section 314) authority. Since authorizations for this Act are due to expire on June 30, 1973, the Administration has requested an extension of this authority.

Provisions of the recently enacted 1972 Social Security Amendments (PL 92-603) significantly affect family planning services. One such provision increases the Federal share of family planning project costs under Titles IV-A and XIX to 90 percent of total costs. This provision establishes a major incentive for States to provide family planning services. The basic support for family planning services to low-income individuals is being shifted from project grant programs administered by the Federal Government to programs for which the States are responsible. Therefore, the Administration has included sharply increased estimates for Medicaid in the FY 1974 budget request to assist the States in implementing their medical assistance plans. Existing programs, currently receiving project grants, are being encouraged to utilize third-party payment mechanisms as their principal source of financial support.

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FEDERAL FAMILY PLANNING STATISTICAL PROGRAM

I. Family Planning Services Statistical Program

The Office of the Assistant Secretary for Health, DHEW, is the focal agency for family planning reports and statistics throughout the Federal Government. Responsibility for a phased development and operation of a National Family Planning Statistical System was assigned to the National Center for Health Statistics (NCHS). Under this assignment, the NCHS has:

- 1) Developed and now operates a coordinated program of statistics on all aspects of family planning service activities programs in the United States.
- 2) Worked with the Office of the Assistant Secretary for Health in the development of standard classifications and terminology and, when appropriate, in consultation with interested government and private organizations.

The Family Planning Services Statistical Program operated by NCHS, has three major activities:

- National Reporting System for Family Planning Services.
- Family Planning Facilities Inventory.
- Special Studies.

A. National Reporting System for Family Planning Services

The National Reporting System for Family Planning Services (NRSFPS) has been developed in two stages: an interim reporting system which was operated by the NCHS from May 1969 through December 1971; and a modified and improved National

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Reporting System for Family Planning Services which is used by all federally supported family planning programs, clinics, and service points and by other agencies who wish to participate. Participants in the NRSFPS include both federally funded and non-federally funded family planning projects. Participation in the reporting system has increased rapidly as shown in the table below:

PARTICIPATION IN NRSFPS, 1970-72

Calendar Year (as of December 31)	Number of Projects	Number of Clinics
1970*	325	890
1971*	458	1,800
1972	684	2,570

*Interim System.

Standard statistical summaries of the data obtained from the NRSFPS are produced on a monthly, quarterly, and annual basis to meet the specific needs of participants. In addition to standard reports, special tabulations may be requested by an interested agency.

B. Family Planning Facilities Inventory

In order to describe accurately the organized family planning activities in the United States, the NCHS is developing a comprehensive inventory of facilities providing family planning services. Once established, this inventory will be maintained on a current basis. Accurate and timely identification of the clinic universe itself is of critical importance to the success of any National Reporting System for Family Planning Services.

The inventory will be a source of information on the characteristics of the clinics themselves. These data will help determine the extent and availability of family planning

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services, the location of the services available, the personnel used for these services, and other relevant characteristics. These data will be useful for administrative planning in both the facilities and manpower areas. Information obtained from NRSFPS and the Family Planning Facilities Inventory together add considerably to the analytical potential of national family planning statistics obtained by the Federal Government.

In order to determine and minimize the definitional and operational problems that might be encountered in the national survey of these facilities, a pretest will be conducted in February 1973, among a sample of 200 projects. This national survey will be conducted in FY 1974 and will cover the total universe of clinics.

The following data items are included in the input form: clinic address, areas served by the clinic, participation in the National Reporting System for Family Planning Services, frequency and hours of clinic sessions, physical location of the clinic or the type of building in which the clinic is located, type of ownership of the facility, medical and family planning related services provided, types of contraceptive methods offered, monthly patient load information, target population of the clinic, and detailed staffing information.

C. Special Studies

Brief descriptions of some of the studies planned during the initial years were submitted in the 1971 report. One example of a special study is a sample survey of the characteristics of dropouts from a family planning program. The effectiveness of a program depends on patients remaining in the program and adhering to their family planning objectives. Dropouts may be program failures; they may have moved out of the area; or they may have decided to have another child.

The objectives of this study are threefold: 1) to determine the reasons for discontinuing the services; 2) to compare the social and demographic characteristics of the patients who discontinued with those who continued; and 3) to obtain an estimate of duplicate reporting in the NRSFPS.

II. National Survey of Family Growth

In addition to the service statistics program described above, the National Survey of Family Growth (NSFG) is being established by NCHS to provide a wide range of information on factors influencing trends and differentials in fertility, family planning practices of the married population, sources from which family planning advice and services are received, the effectiveness and acceptability of the various methods of family planning, and those aspects of maternal and child health that are most directly related to childbearing and family planning.

Data for the NSFG will be collected once every two years in personal interviews with nationwide probability samples of married women in the childbearing ages. The NSFG will be basically cross-sectional in design, but longitudinal features will make it possible, from time to time, to recontact certain subgroups of women interviewed in the biennial surveys in order to obtain additional information from them as they proceed through the childbearing period.

Previous surveys conducted by private organizations have amply demonstrated the feasibility and usefulness of this sort of inquiry, and the plans for the NSFG are based solidly upon their experience. In scope and content, the NSFG will be most similar to the Growth of American Families Surveys of 1955 and 1960¹ and the National Fertility Studies of 1965 and 1970.² However, the design of the NSFG represents an advance over the earlier surveys in scale, frequency, and continuity as demanded by present program information needs.

The NSFG has been primarily designed to produce needed data in three broad areas: demography, family planning, and health. The questionnaire developed for the first biennial cycle of the survey deals with these three areas in the following detail:

¹These studies were conducted by the Survey Research Center of the University of Michigan and the Scripps Foundation for Research in Population Problems, Miami University, Oxford, Ohio. They were financed largely by the Rockefeller Foundation.

²These studies are being conducted by Princeton University with funding under contract with the National Institute of Child Health and Human Development.

Demography: The NSFG will contribute to a clearer understanding of current trends and differentials in the birth rate by providing at regular two-year intervals detailed information on such topics as desired family size, family planning practices, family planning motivation, and the physiological capacity to bear children, for the various social and economic groups within our population. In addition, each respondent will be asked questions about the number of children she actually expects or intends to have, and when she expects to have them. Particular emphasis will be placed on the respondents' expectations with regard to childbearing and childspacing during the two-year and five-year periods immediately following the interview. Questions of this type are designed to elicit responses which will provide a basis for preparing more realistic forecasts of future births.

Family Planning: The results of the NSFG will aid in the effective planning, management, and evaluation of federally supported family planning programs. The NSFG will identify those women who have received advice and assistance from family planning programs. Data from questions on such topics as desired family size, family planning practices, and fecundity will provide one important basis for estimating the size and characteristics of the total population in need of assistance in family planning and will also be helpful in determining the nature and severity of the problems faced by this group. Such regularly collected data will indicate the extent to which efforts to help the population in need are succeeding. In addition, the NSFG will collect a very large amount of information concerning the use, effectiveness, and acceptability of the different methods of family planning within major population groups. This will offer guidance not only for family planning programs, but also for research activities in the development of new means of contraception.

Health: Another need, which the NSFG fulfills, is the demand for information on the number of women who are using oral contraceptives and other new means of family planning, such as IUDs, to control their fertility. Since the possible health hazards of these drugs and devices have not yet been fully determined, it is especially important to follow trends in the number of women who are using these methods in the different age and socioeconomic groups of the population. Investigators monitoring possible health hazards need this information for use in conjunction with relevant data on morbidity and mortality.

DEPARTMENT OF HEALTH, EDUCATION
AND WELFARE
LOCAL HEALTH SERVICE
HEALTH SERVICES AND HOSPITAL HEALTH
ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS

NAME (LAST) (FIRST) (MIDDLE) (SUFFIX)
ADDRESS (STREET)
(CITY) (STATE) (ZIP CODE) (PHONE NO.)

PREPARED BY (PRINT NAME)
PATIENT NO.

CONFIDENTIALITY ASSURANCE All information which would permit identification of an individual will be held in strict confidence, will be used only by persons engaged in and for the purpose of the survey, and will not be disclosed or released by NCHS to others except for statistical purposes. The provision of services is in no way contingent upon the patient's providing any information on this form.

(DETACH THIS PART AND RETAIN AT THE CLINIC)

1. CLINIC NUMBER

2. PATIENT NUMBER

3. DATE OF VISIT

4. TYPE OF VISIT

- ☐ Initial Visit
☐ Visit (first visit this year)
☐ Visit (not first visit this year)

5. DATE OF BIRTH

6. SERVICES PROVIDED

a. MEDICAL SERVICES

- ☐ Pap Smear
☐ Pelvic Exam
☐ Breast Exam
☐ Blood Pressure
☐ Pregnancy Testing
☐ V.D. Testing
☐ Urinalysis (n.e.s.)
☐ Blood Test (n.e.s.)
☐ Sterilization
☐ Infertility Treatment
☐ Other

b. COUNSELING

- ☐ Sterilization
☐ Contraception
☐ Infertility
☐ Other
☐ Referred Elsewhere
☐ None
☐ Abortion
☐ Sterilization
☐ Infertility Services
☐ Other Medical Services
☐ Social Services

7. Contraceptive Method at the End of This Visit

- a. Method**
☐ Oral (Pill)
☐ I.D.
☐ Diaphragm
☐ Foam
☐ Rhythm
☐ Condom
☐ Injection
☐ Sterilization
☐ Other
☐ None
☐ Intermittent Method

b. If None, for reason

- ☐ Pregnant
☐ Other Medical Reason
☐ Seeking Pregnancy
☐ Other

8. Appointment

a. Date

b. Purpose

- ☐ Supply Only
☐ Annual Medical
☐ Other Medical
☐ Other
☐ No Next Appointment

AGENCY USE

NCHS OEO MCHS PPWP NCHS LOCAL

a.

b.

c.

d.

e.

f.

Has a Clinic Visit Record been submitted to the NCHS National Family Planning Reporting System for this patient since Jan. 1, 1972?

- ☐ No - Complete items 10 through 18 below
☐ Yes - then

Is this the first Record completed for this patient this year?

- ☐ Yes - Complete only items 10, 11, 12 below
☐ No - Stop here

10. Pregnancy History

- a. Number of Live Births
b. Number of Fetal Deaths
(Stillbirths, Abortions & Miscarriages)
c. Number of Children Now Living

11. Welfare Status

- a. Are You or Anyone in Your Family Receiving Public Assistance?
b. Are You or Anyone in Your Family Registered for Medicaid?

12. Highest Grade of School Completed

- None Elementary School High School
Code 0 1,2,3,4,5,6,7,8 9,10,11,12
College More Than 4 Years College
Code 13,14,15 or 16 17

13. Place of Birth

14. Latin-American Origin or Descent

15. Race ☐ White ☐ Am. Ind.
☐ Black ☐ Other

16. Sex ☐ Female ☐ Male

17. Source of Referral

- ☐ Outreach Worker
☐ Other FP Clinic
☐ Hospital or
Other Health Agency
☐ Private Doctor or Nurse
☐ Welfare Agency
☐ Another Clinic/Patient
☐ Family or Friend
☐ TV, Radio, Paper, Ad
☐ Other
☐ Unknown

18. Contraceptive History

a. Have You Ever Used Any Method to Prevent Pregnancy?

b. Are You Currently Using Contraception?

c. What is the Last Method Used? (Check One)

- ☐ Oral
☐ IUD
☐ Diaphragm
☐ Foam
☐ Rhythm
☐ Condom
☐ Injection
☐ Other

d. Who Prescribed that Method?

- ☐ Clinic
☐ Private Doctor
☐ Drug Store (over-the-counter)
☐ Other

THE POPULATION COUNCIL

245 PARK AVENUE
NEW YORK, N.Y. 10017

TELEPHONE (212) 687-8330
CABLE: POPCOUNCIL, NEW YORK

June 8, 1973

The Honorable Alan Cranston
The United States Senate
Washington, D.C.

Dear Senator Cranston:

We are writing you jointly, as fellow Commissioners, out of our deep concern about proposals, now under consideration by your Committee, that would seriously weaken the population and family planning program efforts of this country, both at home and abroad.

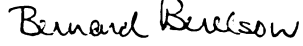
If we are informed correctly, there is some danger that the IUD and sterilization, as well as pregnancy counseling, may be limited in the revised Act, and that research work that might be considered to involve "abortifacients" would be proscribed. We can hardly believe that such restrictive methods are under serious consideration, though we can certainly understand the political pressures that may be applied in this direction, but we do know that with your Commission background in this field you will appreciate what a very difficult situation that would leave us in with regard to our international stance, not to mention the depressing impact on necessary biomedical research nor the impositions upon medical standards and personal freedoms here in the United States.

We write to you thus briefly only to express our concern, since we feel sure that you must appreciate the ramifications, and we trust that you will use your good offices in this regard. If there is any assistance we can properly give you on this matter, please do not hesitate to let us know.

Yours sincerely,


John D. Rockefeller 3rd

Yours sincerely,


Bernard Berelson
President

Center for Family Planning Program Development



June 8, 1973

The Technical Assistance Division of
Planned Parenthood World Population

515 Madison Avenue
New York, N.Y. 10022
Telephone (212) 752-2100

The Hon. Alan F. Cranston
Special Subcommittee on
Human Resources
Senate Committee on Labor
and Public Welfare
Senate Office Building
Washington, D.C.

Dear Sen. Cranston:

It has come to my attention that in her testimony on S. 1708, Mrs. Engel referred to a table which I prepared in a memorandum to Bernard Berelson in 1969. Since this table has been cited out of context by Right-to-Life groups in many areas of the country, I would hope that you could include the entire memorandum in the hearing record, and a copy is enclosed for that purpose.

As will be apparent from the memorandum, the table takes a number of measures which have been discussed in the literature as possible elements in a population policy to reduce fertility and classifies them according to whether they would conceivably affect all groups in society equally or whether they would affect primarily particular socio-economic groups. It should be clear that the authors of the articles or books cited did not necessarily advocate any of the specific measures. I would be very surprised, incidentally, if any of the research from which the table is drawn was financed with Federal funds.

The memorandum makes clear that neither I nor the Planned Parenthood Federation of America advocates any of the specific proposals embodied in the table which go beyond voluntary actions by individual couples to space and limit births.

Sincerely,

Frederick S. Jaffe
Director

FSJ/11
Encl.

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The Technical Assistance Division of Planned Parenthood-World Population

Center for Family Planning Program Development

March 11, 1969

545 Madison Avenue, New York, N. Y. 10022
(212) 752-2100

TO: Bernard Berelson

FROM: Frederick S. Jaffe

RE: Activities Relevant to the Study of Population Policy for the United States

This memorandum is responsive to your letter of January 24, seeking ideas on necessary and useful activities relevant to formation of population policy, defined as "legislative measures, administrative programs, and other governmental actions (a) that are designed to alter population trends... or (b) that actually do alter them." My observations will be limited to the United States and to activities which might shed light on the necessity for, desirability of and in some cases, the potential hazards, of the development of an explicit governmental population policy or policies in the United States.

Apart from the abstraction that in the long run, a zero rate of population growth is inevitable, the arguments advanced to justify an explicit U.S. policy now of encouraging a specific universal limit on family size (as distinguished from proposals aimed selectively at welfare recipients and racial groups) center mainly on two propositions:

1) That continued U.S. population growth will inevitably cause a deterioration in the quality of life of this and future generations; this can be described as the ecological position.*

2) That an explicit U.S. policy to encourage or compel smaller family size in the U.S. is necessary to enable our government effectively to encourage or compel developing nations to move in similar directions; this may be termed the international public relations position.

*A variant of this position is that the U.S., with some 6 percent of the world's population already uses more than half of the world's non-renewable natural resources, and that population growth here thus effects not only the quality of American life but the opportunity of the developing countries even to attempt to improve their living standards.

- 2 -

The debate thus far (in government, among conservation organizations, in the demographic field, within Planned Parenthood, etc.) has with only a few notable exceptions (e.g. Coale) virtually ignored current actual U.S. fertility behavior and its implications for public policies and programming. It has not seriously grappled with public policies in other areas which may influence the realization of fertility preferences, nor with the predictable political consequences of a major effort to adopt and enforce an anti-natalist U.S. population policy. Nor has it viewed population policy as an element -- but only one -- of a larger field of social planning in which the direct and indirect costs and benefits of each element must be weighed against the direct and indirect costs and benefits of all elements in order to produce a coherent social policy.

Realistic public policies intended to influence actual behavior are rarely adopted in the U.S. only for public relations reasons. Proposition 2 above, therefore, is not likely to become the primary basis for a U.S. population policy, no matter how superficially attractive it may be in argumentation and debate. The decision on a U.S. population policy will ultimately be made on the validity or invalidity of Proposition 1.

Accordingly, at least as regards the United States, I believe that a number of activities must be undertaken as prior and necessary conditions to consideration of whether or not the U.S. should adopt any explicit population policy.

These suggestions are set forth below, more or less in the order required, logically, for prior questions to be answered authoritatively before derivative issues are tackled. The first activities are designed to provide a definitive assessment of the levels of population growth that can be expected from expanding to the maximum current voluntary control mechanisms; these studies would offer an answer to the basic question, "Does the U.S. need an explicit population policy?" If there then will still remain some definable problem of population growth in the U.S. on a best-judgment basis, the second group of studies would attempt to clarify the terms of the discourse over alternative policies by removing the value-laden assumptions which have thus far distorted professional and public thinking. Then, it is proposed that a wide range of public policies in the other areas -- and their underlying theoretical bases -- be examined disinterestedly to determine what impact, if any, they have had on population trends. Finally, the list of potentially effective alternative policies which emerges should be critically assessed in terms of their likely political and social consequences in a stratified society.

I. The Uses and Limits of a Contraceptive Society

The U.S. has achieved near-universal practice of some form of fertility control (including ineffective methods). The argument for a U.S. population policy rests on the expressed preference of U.S. couples for an average ideal family of 3+ children which will result in a rate of growth which is said to be impermissible. (It is important to note that the number wanted is usually less than the number regarded as ideal.) Yet, current

- 3 -

fertility experience appears to go in the opposite direction: the annual fertility rate is now about 85 which, if continued, would result in an average completed family size of about 2.6 children; this is being accomplished in spite of the present state of technology, ranging from relatively efficient-to-inefficient contraceptive techniques and, for all practical purposes, with no legal abortion backup; current fertility therefore includes a sizeable number of unwanted births and conceptions. (Data from the 1965 National Fertility Study yields a minimum estimate of 850,000 unwanted births annually from 1960-65, or 21 percent of all births.* While overall fertility has declined since 1960-65, it seems highly likely that current fertility includes at least a 15 percent incidence of unwanted births. If this is valid, the "wanted" fertility rate currently is between 70-75, which is replacement level, if it continued.)

There are, of course, excellent reasons for caution in projecting future trends based on current fertility experience: the fertility preferences of American couples are not static and vary in response to conditions which are only dimly known. But the same caveat applies even more strongly to extrapolations from the post-World War II pre-pill period (upon which much of the demand for a U.S. population policy is based): these projections appear to have been rather considerably modified by the availability of improved contraceptive techniques since 1960 and the degree to which these methods have contributed to delaying first births and introducing longer intervals between subsequent births. Moreover, the interaction between improved fertility control and fertility preferences are only beginning to be clarified by scholars like Freedman, Westoff and Ryder who have shown that "later equals fewer".**

I imagine that it was data such as these which led Coale last November to state that there seems to be as much reason to believe that the U.S. will shortly be worrying about too few births as about too many.***

Since the U.S. has the resources to make truly efficient contraception truly available to everyone and to complement this with abortion on demand, it could thus provide a test of the uses and limits of voluntary action in solving the population problem.

The following work would appear indicated:

- 1) A definitive study of the current number of unwanted births in the United States.
- 2) A definitive study of the current number of illegal abortions in the United States.
- 3) From 1 and 2, an assessment of the likely rate of growth following the virtual elimination of unwanted pregnancy in a society in which

*Jaffe, Frederick S. and Alan F. Guttmacher, "Family Planning Programs in the U.S.", Demography (forthcoming).

**Freedman, R.C. Coombs and L. Bumpass, "Stability and Change in Expectations About Family Size - A Longitudinal Study", Demography 1965, V.2; N.B. Ryder & C.P. Westoff, "The Trend of Expected Parity in the U.S. - 1955, 1960, 1965", Population Index, April-June, 1967.

*** At PPWP's Annual Meeting Symposium.

- 4 -

effective contraception is efficiently distributed to all who want it and abortion is available on demand as a backup measure.

4) Delineation of the necessary and sufficient conditions for achieving such a society:

- a) public and private resources: funds, professional cadres, priority.
- b) efficient contraceptive technologies.
- c) distribution systems.
- d) legal, political and institutional changes (and the requirements for inducing them).
- e) open questions requiring additional research.

5) Assessment of the political, social economic and cultural consequences of the likely rate of growth indicated in 3, or the benefits against which the costs of achieving a truly contraceptive society (as in 4) could be weighed.

The hypothesis underlying these proposals is that the achievement of a society in which effective contraception is efficiently distributed to all, based on present voluntary norms, would either result in a tolerable rate of growth, or go very far toward achieving it. If this hypothesis is basically confirmed, it would negate the need for an explicit U.S. population policy which goes beyond voluntary norms.

II Clarifying the Terms of the Discourse

The present discourse on population policy is loaded with assumptions, biases and judgments about the causes and determinants of fertility behavior, and these assumptions are imbedded in the very terminology employed. Some of these assumptions go back in the literature for decades and centuries (e.g., Malthus' "population bounty") but have never been subjected to empirical verification. Instead, they have been accepted as conventional wisdom and in turn, tend to impede and distort clarification of the issues involved in assessing alternative policy proposals.

It is proposed, therefore, that certain key terms and assumptions be clarified and subjected to empirical test, to the extent data and research would permit:

1) Are free social services "pro-natalist"?

The idea that provision of free social services has a pro-natalist effect is accepted almost uncritically in the literature and in turn, becomes a major postulate on which alternative proposals are based. Empirical analysis is needed to determine the extent to which this characterization is valid as to outcome (as distinguished from the rhetoric advanced to justify adoption of the particular policy in the first place).

For example, is there any evidence that fertility among comparable classes is higher in countries, states or communities which make the following services available, free, to large numbers of couples than in countries,

- 5 -

states or communities which do not?

Maternal and Child Medical Care
Maternity Leave and Benefits
Child Care Facilities
Compulsory Public Education Through High School
College Education (or scholarships liberally available)

These services of course, have positive benefits to society which go beyond fertility (although some may have a subsequent effect on fertility also — and not in the pro-natalist direction). They appear to be characterized as "pronatalist" only because they do not directly penalize child-bearing but there appears to be no evidence that they do indeed encourage fertility, in the United States or elsewhere. In fact, areas and nations providing more free social services appear, on superficial analysis, to have lower fertility, but this may be explained on other grounds (e.g. higher living standards). Nevertheless, the influence or lack of influence of these services on fertility should be established.

2) Economic "incentives" to fertility

A special case of (1) relates to the presumed "incentive" to fertility in such programs as family and children's allowances. These allowances were (and are) legitimated politically as a means of increasing the birth rate, but the only analyses thus far of the actual results yield no support for their presumed pro-natalist effect. Yet, based on the initial justification and the ensuing terminological/ideological set, many proposals are advanced to reduce, eliminate or block family allowances on fertility grounds.

A definitive empirical study is needed of the fertility outcome of family allowance programs, both to inform the forthcoming U.S. debate on restructuring the welfare system and to shed light on the potential usefulness of economic incentives (and thus disincentives) in shaping fertility trends.

A definitive empirical study is also needed of the specific American variant in this area — namely, the frequent allegation that AFDC mothers have more children in order to increase their monthly allotment. This notion is widely held among influential citizens and policy-makers and is one of the powerful stimulants behind the demand for a U.S. population policy.

III Assessment of the Impact on Population Trends of Other Public Policies

Considering the theoretical importance which is attached to social and economic factors in shaping population trends, it is remarkable how little attention has been paid to the effects on fertility of public policies in areas affecting basic social and economic structure. Only recently, for example, it has been suggested that differential welfare standards are a factor stimulating migration (with little or no empirical evidence).

It would seem useful, therefore, to seek some assessment of the actual or anticipated effect on population of current policies, such as:

- 6 -

1) Fiscal and Monetary Policy which appears to regard inflation as a concomitant of full employment and thus, to accept relatively high (or at least preventable) unemployment levels as necessary. Yet, more women enter the labor market under conditions of full employment and the relationship between employment of women and lower fertility seems well established. An examination is needed of, in effect, the question: How much inflation could or should we risk to achieve lower fertility? (XX risk of inflation = YX increase in women's employment = ZX reduction in fertility.)

2) Education Policy; At least two aspects seem worth study:

a) The effect on fertility of policies to encourage higher educational levels for everyone (assuming that the alleged "pro-natalist" effect of free education discussed in II can be reconciled with demographic research showing the inverse relationship of education and fertility); and

b) The effect on fertility of current policies and programs regarding the education of women (for example, to prepare them either for motherhood or labor-force participation, earlier or later marriage, etc.), and the likely effects of alternative policies.

3) Manpower Policy -- this is closely related to 1 and 2; the extent to which current policies, ranging from training and apprenticeship requirements to transferability of pension plans, encourage or discourage women to work should be examined. A specific aspect of this analysis would be the extent to which public policy facilitates or discourages the employment of young mothers through provision or denial of child care facilities (assuming again a reconciliation of this program with the alleged "pro-natalist" effects discussed in II).

4) Farm Policy -- The extent to which the governing U.S. farm policy of encouraging the amalgamation of family farms into "agrobusinesses" has contributed to rural-urban migration during the last 20 years should be examined.

5) Welfare Policy -- The extent to which unlivable assistance levels and inadequate medical and social services, coupled with stigmatization of recipients, have contributed to higher fertility should be explored.

6) Housing Policy -- To what extent has the policy of encouraging small home ownership and suburban development encouraged higher fertility levels? What would be the likely effects of alternative policies?

7) Economic Theory and Policy -- A special case is the area of economic policy because it is widely believed that population growth is indispensable to economic growth. Whether we like it or not, this is probably the controlling idea in the business community and among many economists, and it is highly unlikely that a population policy aimed at lower rates of growth will be adopted until this concept is replaced. Two approaches are suggested:

a) A study tracing the function -- explicit or implicit -- of population growth in the models propounded by economic

- 7 -

theorists historically. The aim of the study should be to answer, in theoretical terms, the question: Among the theories of economic growth in advanced countries which control policy and business decision-making today, is continued population growth an indispensable or dispensable element?

- b) Encouragement of work by appropriate economic theorists to develop a substitute for population growth in the current controlling models of economic growth in advanced countries.

The studies outlined above would shed light on the effect on population trends of some existing public policies; identify the interests benefitting from these policies; and hopefully identify some points for intervention to encourage lower fertility without the adoption of an explicit population policy.

IV Assessment of the Effectiveness of Population Education In Influencing Fertility Preferences

Expansion of educational activities designed to increase awareness of the population problem has been advocated, both in terms of its intrinsic merits and as part of an overall population policy. Projects should be undertaken to delineate the content, scope and limits of such activities as a guide to programs in the schools and by private groups, and studies should be conducted to test the effectiveness of these programs in actually influencing fertility preferences.

In this area, it seems particularly important to distinguish between education and indoctrination. Whatever may be the merits and effectiveness of a truly educational effort, an indoctrination campaign may well have only negligible effects on fertility values, but may provide unintended support in building a public opinion which seeks legalized compulsory fertility control for selected groups (particularly welfare recipients). The adverse political consequences of such a development on the population and family planning fields, nationally and internationally, could be quite serious.

V Assessment of the Political and Social Consequences of Alternative Population Policies in a Stratified Society

The debate in the United States thus far has proceeded with almost no explicit acknowledgement of the fact that the U.S is an economically and racially stratified society. Yet it is clear that most of the policies proposed as alternatives to family planning cannot be expected to affect all segments of the population equally. The attached table attempts a rough sorting of the principal measures discussed, according to whether their impact would be universal or selective. Clearly policies which are primarily economic in effect -- tax policies, incentives and disincentives -- cannot be expected to have equal influence on the behavior of rich middle-class and low-income families. Other proposals -- e.g., compulsory abortion of out-of-

- 8 -

wedlock pregnancies -- can be expected to be applied selectively against those out-of-wedlock pregnancies which are visible, and this has racial overtones. Social stratification thus raises sharply the issue, "Who shall decide whose fertility -- and for whose purposes?"

It seems urgent, therefore, that the policies which emerge as apparently useful from the work proposed in I - IV above be subjected to critical scrutiny in terms of the realities of a class-and race-stratified society. Such an analysis should establish which policies can be administered universally and which can be expected to have a differential impact on various segments of the population. The political consequences of such differentiation should be examined, in an effort to provide working answers to questions such as these:

1) Is it feasible to expect that society will accept policies which curb fertility universally -- or is it more likely that those who are powerful will favor and adopt policies which affect primarily those who have less power or are powerless? Is such differential treatment politically viable?

2) Is it possible to propose and justify universal fertility control policies without reinforcing and legitimating -- politically, philosophically and ideologically -- the existing body of opinion which, for reasons having little to do with the population problem, already seeks selective compulsory fertility control of welfare recipients and minority groups?

These studies, in my view, would be necessary for a clear answer to the key questions surrounding an explicit population policy in the United States namely:

Do we need one -- and if so, how soon?

Is the anticipated gain worth the likely cost?

PROPOSED MEASURES TO REDUCE FERTILITY, BY UNIVERSALITY OR SELECTIVITY OF IMPACT IN THE U.S.

UNIVERSAL IMPACT	SELECTIVE IMPACT DEPENDING ON SOCIO-ECONOMIC STATUS		Measures Predicated on Existing Motivation to Prevent Unwanted Pregnancy
	Economic Deterrents/Incentives	Social Controls	
Restructure family: a) Postpone or avoid marriage b) Alter image of ideal family size Compulsory education of children Encourage increased homosexuality Educate for family limitation Fertility control agents in water supply Encourage women to work	Modify tax policies: a) Substantial marriage tax b) Child tax c) Tax married more than single d) Remove parents' tax exemption e) Additional taxes on parents with more than 1 or 2 children in school Reduce/eliminate paid maternity leave or benefits Reduce/eliminate children's or family allowances Bonuses for delayed marriage and greater child-spacing Pensions for women of 45 with less than N children Eliminate Welfare payments after first 2 children Chronic Depression Require women to work and provide few child care facilities Limit/eliminate publicly financed medical care, scholarships, housing, loans and subsidies to families with more than N children	Compulsory abortion of out-of-wedlock pregnancies Compulsory sterilization of all who have two children except for a few who would be allowed three Confine childbearing to only a limited number of adults Stock certificate permits for children <u>Housing Policies:</u> a) Discouragement of private home ownership b) Stop awarding public housing based on family size	Payments to encourage sterilization Payments to encourage contraception Payments to encourage abortion Abortion and sterilization on demand Allow harmless contraceptives to be distributed nonmedically Improve contraceptive technology Make contraception truly available and accessible Improve maternal health care, with family planning as a core element

The measures tabulated here are derived primarily from Davis, Science, 11/10/67; Michael Young's remarks at NIH Conference 6/67; L.A. Day, Too Many Americans, J. Blake in Shope & Midway, Public Health & Population Change; and W. Shockley, Speech in Ontario, 12/57.

Center for Family Planning Program Development



September 6, 1973

The Technical Assistance Division of
Planned Parenthood World Population

515 Madison Avenue
New York, N.Y. 10022
Telephone: (212) 752-2100

Senator Alan Cranston
Room 2213
Senate Office Building
Washington, D.C.

Dear Senator Cranston:

When I appeared before your Committee on May 8 in connection with hearings on S. 1708, you asked us to provide some estimates of funding available from non-Federal sources to support organized family planning services. Such estimates are difficult to make, but we have tried to assemble whatever information is available to form at least a rough picture of the current situation. These data (and their sources) are as follows:

State Legislative Appropriations*	\$4.3 million
Local Government Expenditures	Not available
Hospital Expenditures Not Covered by Government Grants**	3.0 million
Planned Parenthood Affiliates, 1972:***	
Fund-Raising Contributions for all purposes (including capital costs)	12.8 million
Fees from Patients	7.7 million
Total	\$29.8 million

(Sources: * - 1972 Center for Family Planning Program Development Survey of State Health and Welfare Policies; ** - This is, in effect, a pure guess; *** - Department of Resources, Planned Parenthood-World Population)

It thus appears that about \$30 million was available from non-Federal sources in 1972 for support of organized family planning services. This might be an underestimate since some city governments may have expended some of their own funds on these services, but the amount is unknown; from field experience, it is not likely to be significant.

Planned Parenthood - World Population

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Chairman Executive Committee
John B. Aasen

President
Alan F. Garmacher M.D.

Chief Executive Officer
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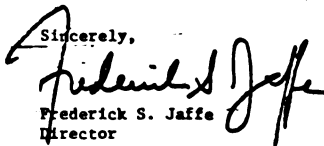
John B. Berman M.D.

-2-

We have no way of determining how much or how little of these funds were used to match Federal funds under either Title X of the Public Health Service Act, or Titles IV-A and XIX of the Social Security Act. Our opinion is that a significant amount has probably been used to match Title X project grants, but that very limited amounts have thus far been used to match Titles IV-A or XIX.

We hope these estimates are useful.

Sincerely,

A handwritten signature in dark ink, appearing to read "Frederick S. Jaffe". The signature is fluid and cursive, with the first name "Frederick" and last name "Jaffe" clearly distinguishable. It is written over the typed name and title.

Frederick S. Jaffe
Director

FSJ/11

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United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

March 30, 1973

Dr. John Ottina
 Commissioner-Designate
 of Education
 U.S. Office of Education
 300 Maryland Avenue, S.W.
 Washington, D.C. 20202

Dear Dr. Ottina:

Last year I exchanged several letters with Dr. Don Davies, former Deputy Commissioner for Development, relating to the environmental education projects supported by the Office of Education, in which I sought to determine how many of these programs included a population education component, and to what extent funds are made available for these purposes.

My last letter to Dr. Davies was dated December 12, and specifically asked for a summary document describing environmental education projects supported by the Office of Education, which Dr. Davies had contemplated completing in November of 1972.

I have not yet received a response and would like to make the request again that this list be furnished the Subcommittee and that those projects which contain a population education component be identified with some designation as to the proportion of the project devoted to this subject.

With many thanks for your cooperation.

Sincerely,

Alan Cranston
 Chairman
 Special Subcommittee on
 Human Resources

COPY /



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION
WASHINGTON, D. C. 20302

MAY 23 1973

Honorable Alan Cranston
Chairman, Special Subcommittee
on Human Resources
Committee on Labor and Public Welfare
United States Senate
Washington, D.C.

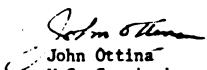
Dear Senator Cranston:

Please accept my apology for the delay in responding to your letter of March 30 requesting information about environmental education projects supported by the Office of Education.

I believe that the enclosed reports will be responsive to your inquiries. One of them lists the population education projects supported under the Environmental Education Act (P.L. 91-516) from Fiscal 1972 funds. The other report summarizes environmental education projects supported by the Office of Education under authorities other than the Environmental Education Act during the same fiscal year. In those projects which do not focus exclusively on population education, it is not possible to determine precisely what portions of their total grants are so used.

We anticipate the continued funding of population education projects, as well as other projects related to environmental education, during the fiscal year.

Sincerely,


John Ottina
U.S. Commissioner
of Education-designate

2 Enclosures

FISCAL YEAR 1972 SYNERGY PROJECTS

1) Vocational Education Act

Minnesota Environmental Sciences Foundation, Inc. \$150,000
 Minneapolis, Minnesota
 Title: Exemplary Vocational Education Program
 Based on Environmental Studies (K-14)

The project is designed to develop awareness to the work, specifically to careers in environmental control; exploratory community experiences in environmental control occupations; job-entry-level skills for water pollution control technicians; expanded vocational guidance and placement services are important facets of the program.

2) Education Professions Development Act, Part E

CUNY Hunter College \$ 88,000
 New York, New York

Sixteen fellowships to college teachers in environmental health science/education.

Tuskegee Institute \$ 65,000
 Tuskegee Institute, Alabama
 Title: Institute in Environmental Science for
 College Teachers

This eight-week summer institute will train two-year and four-year college teachers in environmental problems, including pollution and misuse of our national resources. It is anticipated that the program will result in greater involvement of minority groups in solving the environmental problems of the nation.

Synergy Project, FY 1972 - page 2

Bowling Green State University \$ 70,000
Bowling Green, Ohio
Title: Summer Institute in Environmental
Management for Teachers

A summer institute for two-year and four-year college faculty in environmental studies programs. The program includes study of ecological principles governing pest species management and environmental pollution, governmental and political considerations, economics, and approaches to solutions.

Wayne State University \$ 65,000
Detroit, Michigan
Title: Institute in Environmental Education
for Junior College Educators

This summer institute will provide training in various aspects of pollution and ecology for junior college teachers from the Midwest. A purpose of the institute is to assist in the establishment of curricula in environmental technology in junior colleges as well as to strengthen general environmental education in the two-year college.

Miami-Dade Junior College \$140,000
Miami, Florida
Title: National Training Program in Environmental
Education for Community College Faculty

This is a nationwide program to train junior college teachers in environmental education. Workshops will be held throughout the country for maximum impact on the junior colleges.

3) Higher Education Act, Title III, Strengthening Developing Institutions.

Lake City Community College \$ 50,000
Florida

Indiana Institute of Technology \$ 45,000
Indiana

Inter-American Univ \$ 75,000
Inter-American Univ

Synergy Project, FY 1972 - Page 3

Projects for development of environmental education curriculum components.

4) Higher Education Act, Title II-B. Librarian Training.

Western Michigan University	\$ 30,000
Kalamazoo, Michigan	
Title: Institute on Environmental Information Programs for Public Libraries	

The purpose of this institute is to train 25 practicing public librarians to be specialists in methods of acquiring, organizing and disseminating environmental-ecological information. Participants will be taught how to establish and maintain an environmental information center. The program will consist of lectures, discussions, field trips, and hands-on activities.

California State College at Long Beach	\$ 25,000
Long Beach, California	
Title: Multi-Media Selection and Production	

An institute for supervisors of school and public libraries on methods of producing and selecting multi-media materials for environmental education.

5) Education Professions Development Act, Part D

Jefferson Union High School District	\$ 48,000
Daly City, California	
Northern Colorado Educational BOCES	\$ 39,400
Boulder, Colorado	
University of Maine at Portland-Gorham	\$ 13,000
Gorham, Maine	
Baltimore City Public Schools	\$ 12,500
Baltimore, Maryland	
University of Nebraska	\$ 30,000
Lincoln, Nebraska	

Synergy Projects, FY 1972 - Page 4

State University College at Buffalo Buffalo, New York	\$ 12,300
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Toledo Public Schools Toledo, Ohio	\$ 29,800
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Department of Public Instruction Pierre, South Dakota	\$ 50,000
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Central Washington State College Ellensburg, Washington	\$ 50,000
--	-----------

Preservice and inservice teacher training programs in environmental education. Most participants of these projects plan to teach at the elementary and secondary education levels.

6) Manpower Development and Training Act, MDTA

Denver Community College Denver, Colorado	\$ 32,000
--	-----------

Seminars sponsored by USOE and Denver Community College to identify desired components of a grade 7 through university environmental curriculum based on integrated pest management.

7) Cooperative Research Act

Population Education, Inc. Washington, D.C.	\$ 50,000
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A project to develop supplemental curriculum material in population education for secondary schools.

8) Public Law 480, International Studies

The Maxwell Graduate School of Citizenship and Public Affairs Syracuse University Syracuse, New York	\$ 94,000
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A twelve month environmental education research and study project to be conducted in Yugoslavia by

Synergy Projects, FY 1972 - Page 5

Syracuse University. The project attempts to facilitate the development of environmental education resource materials based on comparative analysis of American and Yugoslav environmental problems and environmental education needs and resources.

Subtotal	; 23 projects,
<u>\$1,254,000</u>	

9) Elementary and Secondary Education Act, Title VIII - Drop-out Prevention

Fall River Public Schools	\$ 60,000
Fall River, Massachusetts	
Title: Water, Air, Conservation of the Environment	

This component of a dropout prevention project involving a group of potential dropouts at the secondary level. Their instructors and student assistants will help them gain environmental understanding and experience, with special emphasis on the condition of water, a local community concern. The students will assist in the study of South Watuppa Pond and the Algae nuisance which besets it; analyses of the local water supply and the waters of Mount Hope Bay; and investigation of thermal and air pollution.

10) Education Professions Development Act, Part E

Western Michigan University	\$ 65,600
Kalamazoo, Michigan	

Twelve fellowships to college teachers in environmental science/studies.

11) Elementary and Secondary Education Act, Title V

Northeastern Environmental Education Development	\$ 71,600
New York State Education Agency	

A project using funds for subgrants or contracts to disseminate materials, develop prototype materials, develop and test instruments etc. which are or can be of significant interest participating States for environmental education purposes. Participating States include Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, Pennsylvania, Rhode Island, and Vermont.

Environmental/Ecological Education Planning Project \$50,000
North Carolina State Education Agency

Project funds are divided among the three participating States to enable them to develop a structure and a program in environmental education at the State level and to enable them to assist other States next year in similar developmental activities. The participating States are Florida, Maryland and North Carolina.

Western Regional Environmental Education \$ 50,000
Cooperative Project
California State Education Agency

Project funds will enable representatives from State educational agencies and State resources agencies to work together in developing and strengthening ways of cooperating to improve environmental education in each State. Participating States are California, Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

12) Elementary and Secondary Education Act, Title III \$2,481.76

Los Angeles City Unified School District
Los Angeles, California
Title: A Model Educational Program in Ecology,
K-Adult Education

A comprehensive program in ecology from k-Adult Education will be developed, implemented and monitored. A sequential program in environmental education will be developed, and instructional

materials for pupil and teacher use will be prepared. An ecology center complex will be established; two mobile ecology laboratories will be developed; and a television series on ecology for elementary and secondary school levels will be produced.

District School Board of Lee County
Fort Myers, Florida
Title: Model Strategy for an Effective
Environmental Education Program

A program to foster environmental awareness, sensitivity and responsibility on the part of students at all grade levels will be implemented. Curriculum materials for grades 6-8 will emphasize understanding ecological consequences. For grades K-5 material; will center on environmental awareness, sensitivity, and very basic ecological concepts. Students will acquire skill in sampling, surveying, and maintaining environmental conditions.

Community Unit School District #200
Woodstock, Illinois
Title: Woodstock Environmental Education
Project

An environmental education program will be established to develop positive attitudinal and behavioral patterns of teachers, students, and other citizens concerning environment so as to effect improvement and enhancement of environmental quality. Students, teachers, and parents will identify environmental problems of the area, State, and Nation; will formulate proposed solutions to identified problems and will develop materials and programs to augment the existing curriculum. Through these activities, participants will gain understanding of ecology and will learn to identify environmental problems and to work through legal means for orderly solutions.

Synergy Projects, FY 1972 - Page 8

Shawnee Mission Unified District #512
Shawnee Mission, Kansas
Title: Cooperative Learning Through Environmental Activities in Nature

An environmental education program will be established which will eventually serve the entire school district. The program will include cross-curricular involvement, interaction among children at all grade levels, indoor-outdoor ecological study, urban-suburban-rural-underdeveloped area field studies, and cooperative use of existing county park facilities and nonprofit outdoor education foundation facilities. An environmental education laboratory will be cooperatively developed. Selected school personnel will participate in a summer workshop to develop the program and related audiovisual materials including programmed cassette tapes for small group student field study.

Unified School District #501
Topeka, Kansas
Title: Environmental Education Demonstration Project

An interdisciplinary environmental education program will be established. The program will include field trips where students will make on-site investigations of various aspects of the environment. When they return to the classroom, the students will develop solutions to environmental problems encountered on their trips. Handicapped children will participate in the program and inservice training will be provided for teachers.

School District of City of Wyandotte
Wyandotte, Michigan
Title: Strategies for Environmental Education - Project SEE

A model environmental education program aimed at developing people who are consciously aware

an active role in efforts to maintain and improve the environment will be implemented. The curriculum will include specially designed environmental education packages which will be utilized by selected students. Efforts will be made to involve the entire community in the project on a continuing basis. University personnel will assist in the preservice and inservice environmental education of teachers.

Sole Supervisory District to Putnam and
Westchester Counties, BOCES
Yorktown Heights, New York
Title: The Area Education Agency's Role in
Developing Environmental Education

An educational program involving two school districts will be developed. Activities in each district will focus on establishment of a multidistrict student environmental monitoring network concerning air, water, soil, waste, noise, and population to function first within the project area and later to spread throughout and beyond the State. The project will also establish a clearinghouse to deal with environmental materials for elementary and secondary education and will plan for the active involvement of State Education Department and State Environmental, Conservation Staff, as well as the 45 other Boards of Cooperative Education Service (BOCES) in the State.

Golden Valley School District #275
Golden Valley, Minnesota
Title: Community Environmental Studies Program
for Grades 5-12.

An environmental studies program will be established to promote environmental literacy through continued exposure to underlying principles and concepts presented within the matrix of the learner's cumulative experience. Participants will make field observations to describe

Synergy Projects, FY 1972 - Page 10

the socio-ecological research, classical design and statistical procedures, controls, social action and survey methods. The learner's knowledge of man-land problems will stem from observations and experiences with environmental problems in the social context within which they occur.

Newark Board of Education

Newark, New Jersey

Title: Implementation of State of New Jersey Plan for Environmental Education

A State plan for environmental education will be implemented. The plan will provide an organizational structure and mechanism for the pooling of Statewide resources in order to create an environmentally literate citizenry which understands its interdependence with the environment, is knowledgeable regarding environmental problems, and is motivated to participate in their prevention and solution. Model multi-media curriculum materials will be developed and field tested, with assistance provided for their implementation for the elementary/secondary level, colleges and universities, continuing education programs, business, industry and labor personnel, government agencies, community action groups, and community planners. Training programs will be developed and operated for school administrators, curriculum developers, teachers, aides, student leaders, undergraduate/graduate education majors, college/university faculty, and resource management personnel as well as those groups noted above. A State environmental center will be established to provide a coordinating function for the above activities, to supervise curriculum development, and to act as a clearinghouse to gather, evaluate, and disseminate information.

Synergy Projects, FY 1972 - Page 11

Catalet County Board of Education
Beaufort, North Carolina
Title: School Community Cooperative Environmental
Studies Project

A program designed to promote self-directed and investigation-oriented learning which molds schooling with education in the "real like" of the community and the total environment by placing students in actual situations to observe the functioning of the socioeconomic system. Three classes of juniors and seniors of "moderate abilities and ambitions" will be placed in a full-year, half-day elective course replacing their regular English, social studies, and science program in order to conduct individual and group field research in the community.

Montgomery County Supervisor of Schools
Norristown, Pennsylvania
Title: Urban-Suburban Cooperative Project in
Environmental Education

A regional research and resource environmental education center and a network of satellite centers will be established to serve a five-county area. Through the centers, a cooperative urban-suburban approach to problem solving will be made. Students, teachers, and community members will interact within the context of environmental education. The centers will develop staff and curriculum, provide consultant services, and establish urban-suburban interchanges of students, teachers, and resources.

Berks County School Board
Reading, Pennsylvania
Title: An Interdisciplinary Problem Solving Approach
in Environmental Education

An interdisciplinary, problem-solving curriculum in environmental education for all age levels will be developed in conjunction with the State-funded construction of facilities at the Nolde Forest State Park. The curriculum will be developed around five

Synergy Projects, FY 1972 - Page 12

and will be pilot-tested in the Park facility and surrounding communities. Teacher training in the use of the facilities and curriculum will also be conducted.

Anderson School District #5

Anderson, South Carolina

Title: An Environmental-Ecological Education Center

An environmental/ecological education center will be established for exceptional students, including academically talented and handicapped students. A resident and day environmental learning center will be developed on a 45 acre site near a lake. There all environmental resources and problems peculiar to the area will be investigated by the participating students and their teachers.

Bellevue Public Schools

Bellevue, Washington

Title: Urban-Suburban Environmental Education Program

Urban elementary and junior high students will explore environmental and intercultural problems and situations on a school-year basis, utilizing class exchange, cooperative field trips, short-term resident outdoor school experiences. A cadre of teachers in environmental education and intercultural activities will be trained to serve as change agents in their particular schools. The outdoor school will provide a neutral atmosphere in which attitudinal changes will be expected, as well as understanding of the ecological balance of

Laramie County School District #1
 Cheyenne, Wyoming
 Title: Eco Curriculum Development and Learning
 Laboratory

A curriculum development and learning laboratory and satellite sites will be established to develop and present an environmental education curriculum for Grades K-12 and a special curriculum for handicapped children. The curriculum will emphasize knowledge of environmental problems, methods of solving these problems and will be developed by instructional teams from social, behavioral and hard sciences.

Milwaukee Public Schools
 Milwaukee, Wisconsin
 Title: Master Plan for Environmental Education
 in the Milwaukee Public Schools

A master plan for environmental education in the school system will be implemented. The program will include teacher leadership conference, a television inservice workshop, curriculum development workshop, an open-end grant program, field trips, pilot program, and similar activities. Teachers selected for the leadership conference will coordinate various environmental education activities in their respective schools. Under the open-end grant program, students will receive assistance for innovative environmental education projects.

12) Cooperative Research Act

Educational Resources Information Center (ERIC) \$ 100,000
 Ohio State University
 Columbus, Ohio

The ERIC system is nationwide and attempts to provide ready access to results of exemplary programs, research and development efforts and related information that can be used in develop-

Synergy Projects, FY 1972 -- Page 14

ing more effective education programs. The Center at Ohio State University deals with the area of environmental education as well as science and mathematics.

Biological Sciences Curriculum Study \$ 100,000
University of Colorado
Boulder, Colorado

A formative evaluation of an environmental module for general biology which provides techniques for student assessment of biological, physical, and behavioral aspects of environmental quality.

Stanford Research Institute \$ 90,000
Stanford, California

Environmental education is an area of concern of the Education Policy Research Center at Stanford Research Institute. They have identified environmental pollution as a serious world problem that has impacted on societal values and which is influencing and can be influenced by education. Through analyses of alternative futures they have emphasized the significance to education of the environmental problems and solutions (alternatives) envisioned.

13) Higher Education Act, Title I -- Community Service and Continuing Education Program

University of Arkansas \$ 9,717
Fayetteville, Arkansas
Title: Community Workshops for Elimination or Control of Environmental Problems

The project will alert citizens and officials in eight Arkansas cities to the legal means commonly available to protect or improve conventional environment. The project

team will study enacted local legislation and will work with city officials, municipal legislators, interested citizens in workshop sessions to identify environmental improvement goals and appropriate legal administrative and educational means to their achievement.

University of Hartford
West Hartford, Connecticut
Title: Hartford Community Environmental
Education Center

\$ 15,000

Three one-week educational retreats will be held for community leaders at the University's Great Mt. Forest Camp in northwestern Connecticut. Follow-up workshops will be held on Saturdays in the Fall. The purpose is to promote better communication among those involved in dealing with environmental problems through improving their conceptual framework for decision-making.

University of Georgia
Athens, Georgia
Title: In Pursuit of Clean Water

\$ 7,000

The purpose of the program is to bring about an environmental consciousness among local and State leaders who are responsible for making decisions concerning the environment, to provide the leadership and concerned citizens the opportunity to share in seeking solutions to water problems. Six workshops on Water Quality and Resources will be conducted in six locations. Participants will include concerned citizens, industry and business leaders, local and State government personnel.

University of Maine \$ 7,790
 Orono, Maine
 Title: Solid Waste Disposal Alternatives
 for Maine Communities

The purpose of the project is to acquaint private citizens and municipal officials with the solid waste management problems and with acceptable alternatives for solid waste management and disposal. A series of one-day public meetings will be held at four locations in the State. The proceedings of these meetings will be published and disseminated. During the same week that the seminars will be held, three half-hour T.V. programs dealing with solid waste disposal will be prepared for later airing on the Maine Educational Television Network.

University of Massachusetts \$ 11,000
 Amherst, Massachusetts
 Title: The Green River Project

The project will use university students to train citizens in the Greenfield area to do basic water sampling needed to monitor the Green River. Five lecture courses for 75 community members will be held on the environmental aspects of the area. Sixteen participants will be further trained to do basic monitoring.

Northeast Mississippi Junior College \$ 12,008
 Boonville, Mississippi
 Title: Environmental Education Program for
 Community Leaders

The university will hold five day-long seminars throughout the northeast section of the State to give a brief coverage of environmental problems and to promote environmental control practices. Two conferences will also be held for area leaders to meet and discuss mutual environmental problems. Four week-long workshops will be conducted on campus for Northeast students, community leaders and other interested area adults to provide in-depth study of specific local problems.

Dartmouth College \$ 12,000
 Hanover, New Hampshire
 Title: Education for Implementation of Upper
 Valley Land Protection

The purpose of the project is to educate land owners and community officials along the Connecticut river toward understanding how they can protect their land from inappropriate development. Seminars will be held on both a regional and town basis.

University of New Hampshire \$ 3,668
 Durham, New Hampshire
 Title: Environmental Field Day

A two-day workshop/seminar will be held to educate a broad section of New Hampshire people about natural resource management at the community level; to provide information that will encourage examination of specific community environmental problems; and to provide a basis for developing community resource management policies and procedures.

North Carolina State University \$ 11,268
 Raleigh, North Carolina
 Title: Environmental Education Program for
 North Carolina

North Carolina State University will conduct a series of environmental education programs directly responsive to the previously stated needs of environmental activists, elected officials, regulatory board members, developers, financiers, and citizens at large. The programs will include issue-oriented workshops, publication of informative articles in the N.C.E.E. Newsletter, and implementation of an Environmental Speakers' Bureau

Synergy Projects, FY 1972 -- Page 18

Shaw University \$ 9,400
 Raleigh, North Carolina
 Title: Environmental Education in Raleigh,
 North Carolina Area

Shaw University will conduct a continuing education program to communicate to the adult population of the Raleigh area facts of environmental pollution and protection. Available scientific and technical knowledge will be disseminated to private citizens groups, civic, governmental, educational and religious organizations through special seminars, workshops, night classes, radio-television broadcasts etc.

Claman State College \$46,300
 Claman, Pennsylvania
 Title: Institute on Human Ecology of Northwestern
 Pennsylvania

Claman State College will conduct multi-disciplinary educational programs for key community agencies and organizations focusing on the processes of solving key environmental problems (both natural and manmade) at the local level.

Indiana University of Pennsylvania \$ 40,000
 Indiana, Pennsylvania
 Title: Institute on Human Ecology of
 Southwestern Pennsylvania

Four colleges in the area will work together on conducting workshops designed to further develop awareness and knowledge about the environment among community leaders. They will also conduct an environmental action program which will serve as a model of interaction between area colleges and community groups. A Speakers' Bureau will be organized for each college.

Synergy Projects, FY 1972 -- Page 19

Parkersburg Community College \$ 5,224
 Parkersburg, West Virginia
 Title: Environment; Economics vs. Social
 Concern

The program is designed to awaken the public interest to the social and economic implications of environmental pollution through education which will foster informed involvement and decision-making pertinent to environmental protection. The program will consist of two lecture series for interested citizens and a two-week seminar for high school and college instructors. The latter will address methods of integrating ecological concerns into on-going classroom activities.

A variety of activities similar to those described above are being conducted at the institutions listed below. The projects are being supported for a second year with HEA Title I State grant funds.

University of Alabama \$ 11,613
 University, Alabama
 Title: Education Services for Government
 Employees working with pollution problems,
 water treatment, and other concerns

Arizona State University \$ 3,439
 Tempe, Arizona
 Title: Community Noise Control Program

Berry College \$ 4,500
 Mount Berry, Georgia
 Title: Community Leadership in the Seventies:
 Environmental Consciousness of Adults

Synergy Projects, FY 1972 -- Page 20

University of Missouri
 Kansas City, Missouri
 Title: An Environmental Pollution Control
 Information Center \$ 6,994

University of Nevada
 Reno, Nevada
 Title: Environmental Studies Program \$ 11,800

University of Nevada
 Las Vegas, Nevada
 Title: Environmental Studies Program \$ 13,400

Dartmouth College
 Hanover, New Hampshire
 Title: Contemporary Regional and Social
 Problems, Including Pollution, Drugs,
 Poverty \$ 10,500

University of New Hampshire
 Durham, New Hampshire
 Title: Resource Newsletter --Managing Our
 Resource Environment \$ 10,500

University of New Mexico
 Albuquerque, New Mexico
 Title: Conference on the Continuous Critical
 Problems of Albuquerque, including Impact
 of the Environment \$ 15,000

New Mexico State University
 Las Cruces, New Mexico
 Title: New Mexico Environmental Institute \$ 15,000

Appalachian State University
 Boone, North Carolina
 Title: Continuing Education in Northwestern North
 Carolina \$ 33,000

Synergy Projects, FY 1972 -- Page 21

Westchester State College West Chester, Pennsylvania Title: The Importance of and Danger to the Ecological Cycle of Pennsylvania	\$ 59,602
Clarion State College Clarion, Pennsylvania Title: Institute on Human Ecology of Northwestern Pennsylvania -- Project NOW	\$ 46,306
St. Edward's University Austin, Texas Title: Environmental Seminars: The Ecological Basis of Urban Problems in Texas	\$ 9,000
Sweet Briar College Sweet Briar, Virginia Title: Environmental Education for Community Leaders	\$ 21,000
Western Washington State College Bellingham, Washington Title: The Future of Puget Sound	\$ 15,000
West Virginia Institute of Technology Montgomery, West Virginia Title: An Action Plan for Dealing with Environmental Pollution and other Community Problems	\$ 8,625

 Subtotal

 \$4,818,640

() . . . projects

FY 1972 ENVIRONMENTAL EDUCATION ACT FUNDED PROJECTS
INCLUDING POPULATION COMPONENTS

1. Rough Rock Demonstration School . \$16,000
 Chinle, Arizona 86503
 John Schneider

Materials for use in Indian Schools and communities will be developed based upon the community's environmental problems, including population characteristics, fuel production, water and air pollution, solid waste management and land erosion. Materials will be written in Navajo and English and presented from the viewpoint of Indian tradition and culture.

2. Ecology Action Educational Institute \$30,000
 Modesto, California 95352
 Cliff Humphrey

The institute will develop a process curriculum model for community education focusing on the county as an ecological system, emphasizing the interrelationship of energy requirements, population, food, recycling, etc.

3. Delaware State Department of Public Instruction \$15,000
 Dover, Delaware 19901
 John Reiher

The Department, through its multidisciplinary Environmental Advisory Committee Task Force, and the Delaware Conservation Education Association, will assist public and private organizations develop curriculum materials for formal and non-formal use. The conceptual scheme of the University of Delaware's population curriculum study will serve as the content framework in the materials.

4. Dade County Public Schools \$43,000
 Miami, Florida 33156
 Tee Greer

The public school system will establish an environmental education center to facilitate the study of the urban environment by secondary students, teachers, and citizens of the community. A focal subject for the Center will be the population dynamics of the urban environment and the various consequences for urban residents.

5. National Association for Environmental Education \$40,000
 Miami, Florida 33156
 F. Mines

In cooperation with secondary education personnel from around the U.S., the Association will develop an environmental studies curriculum, Man and Environment. A primary section of this curriculum will be devoted to population as a key factor in the interrelationship of man/environment.

-2-

FY 1972 EE Funded Projects including Population Components--contd.

6. Florida State University \$20,000
Tallahassee, Florida 32306
Rodney Allen

The university will design, produce and evaluate 12 instructional units and accompanying teacher guides in humanistic education, focused on the ethics of man-land-nature relations.

7. Pacific and Asian Affairs Council \$9,500
Honolulu, Hawaii 96822
James Narpstrite

The Council will work closely with high school students to develop a curriculum for community education, dealing with issues of major importance to the environment of islands, particularly the relationship of population growth and its consequences to Hawaii.

8. Morehead State University \$18,000
Morehead, Kentucky 40351
Jerry Howell

The university will develop and disseminate, through student projects, reference and resource materials addressing the major causes and consequences of local environmental conditions. The specific target groups will include public schools, local businesses, and civic organizations.

9. Foresta Institute \$5,500
Carson City, Nevada
Richard Miller

The Institute will conduct a series of seminars for representatives of community, business, industry, and education to investigate topics of local and regional concern, including population dynamics, energy needs, water demands and pollution.

10. Wisconsin Vocational, Technical and Adult Education \$7,000
District #18
New Richmond, Wisconsin 54017
Arthur Cothran

The "Advotech" District will conduct 25 environmental studies seminars and workshops in five cities and villages for public employees engaged in waste treatment plant operations. One of the main topics to be addressed will be the relationship of population phenomena to the need for and alternatives in waste treatment.

POPULATION ORIENTED ENVIRONMENTAL EDUCATION PROJECTS -- FY 1972

1. Alexis DuPont School \$13,000
Thomas S. Hounsell, Director
Population Environment Project
Greenville, Delaware 19807

A curriculum development workshop for 20 individuals to prepare population environmental studies material for the school district's multidisciplinary K-12 curriculum with an objective of individualizing the total curriculum as related to population environment concepts.

2. Indiana University Foundation \$35,000
Jerry L. Brown, Director
Bloomington, Indiana 47401

Development and evaluation of a 12th grade instructional unit on population-environmental affairs. The material is designed for use by schools throughout the country.

3. University of North Carolina, Chapel Hill \$20,000
Art Hurow, Director
UNC Chapel Hill, N. C. 27514

Development of two experimental inservice teacher training courses in population education. The courses will make use of population education curriculum materials being developed by the university and will be offered through the statewide system of community colleges.

4. Fargo-Moorehead Chapter \$4,000
Zero Population Growth
David E. Walsh, Director
Fargo, North Dakota 58102

The Fargo-Moorehead Chapter of Zero Population Growth will conduct a pilot project designed to disseminate the effect of man's activities and life style on the environment to the rural population in North Dakota and northwestern Minnesota by establishing environmental booths and exhibits at state and county fairs.

5. University of Cincinnati \$5,000
Judith Schultz, Director
Cincinnati, Ohio 45236

The University of Cincinnati will develop and implement a one-quarter in-service training course on population education for 35 junior-senior level teachers. The project will utilize an interdisciplinary approach to population education. The course will be team taught by specialists in history, political science, biology, and sociology. Emphasis will be upon factual information and the development of classroom applications within various disciplines.

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United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

May 14, 1973

Dr. John J. Billings
 141 Grey Street
 East Melbourne, 3002
 Victoria, Australia

Dear Dr. Billings:

During hearings before the Special Subcommittee on Human Resources, a witness, Mrs. Terry Siller, Secretary, Nassau County Chapter, Women for the Unborn, reported on the Ovulation Method which you have developed and suggested that the Subcommittee seek your comments on the legislation under consideration.

A copy of the proposed legislation, a copy of my remarks on introducing the legislation, which will provide you with a description of the intent and history of the legislation, and a copy of Mrs. Siller's testimony follow separately. Your comments on the proposed legislation are invited, and will be included in the hearing record when printed. Our hearing record will close June 5, two weeks after our last scheduled hearing, but in view of the distance our correspondence must travel, I could make an exception in your case to hold the record open somewhat longer. I would appreciate a reply as soon as possible, however, so that we can proceed to publish the hearings.

I look forward to hearing from you.

Sincerely,

Alan Cranston
 Chairman, Special Subcommittee
 on Human Resources

cc: Mrs. Terry Siller

COPY

Comments by Dr. John J. Billings made at the request of Mr. Alan Cranston, Chairman, special sub-committee on Human Resources, United States Senate, Washington.

1st June, 1973

My name is John J. Billings. I am a legally qualified medical practitioner residing at 360 Cotham Road, Kew, 3101 and practising medicine as a Consultant Physician Neurologist at 141 Grey Street, East Melbourne, 3002, in the state of Victoria, Australia. I am a member of the Australian Medical Association, a Fellow of the Royal Australasian College of Physicians and a Member of its Council, a Fellow of the Royal College of Physicians of London, and a member of the Australian Association of Neurologists. I represent the Royal Australasian College of Physicians on the National Health and Medical Research Council of Australia and am Chairman of the Medical Research Advisory Committee of the National Health and Medical Research Council. I hold the post of Honorary Consultant Neurologist to St. Vincent's Hospital in Melbourne, and Physician in Charge of the medical clinic, Royal Victorian Eye and Ear Hospital. During the past 20 years I have been interested in the subject of natural family planning and am Senior Consultant to the Family Planning Clinic, Department of Community Medicine, St. Vincent's Hospital Melbourne.

It is with great pleasure that I accept the invitation to offer a submission to the Chairman and Members of the Human Resources Sub-committee, and I should like to place my gratitude on record. I am grateful also for having received a copy of the proposed Bill (Senate Bill S.1708) and of the testimony of Mrs. Therese D. Siller given on May 10, 1973.

My involvement in natural family planning arose out of my adherence to the Catholic religion. At first we concerned ourselves with the need to provide an effective solution for the problems of those married people who refuse, as a matter of conscience, to use any form of artificial contraception. Contrary to the expectations of many people five to ten years ago, interest in the natural methods has increased as newer techniques have been developed and as the ill-effects that so often follow the use of artificial methods have been more widely appreciated. Apart from the individual problems which are encountered in the affluent Western societies, increasing difficulties have arisen in the implementation of birth control programmes in the developing countries involving contraceptive

medication, intrauterine devices, sterilisation and abortion. There is much greater resistance to contraceptive medication, the various loops and to sterilisation in the developing countries than elsewhere, whilst the use of abortion as a method of control of population is repudiated by the majority of people in almost every country.

A natural method of family planning is, by accepted definition, one which takes advantage of the biological fact that women are infertile for most of the time throughout the reproductive period of their lives. Even when allowance is made for survival of the husband's sperm cells, an act of sexual intercourse is incapable of causing pregnancy on the majority of days in every menstrual cycle. In using a natural method the act of intercourse remains completely normal.

Excluded therefore from the definition of a natural method are coitus interruptus, condoms, contraceptive creams, diaphragms, contraceptive medication, intrauterine devices, immunisation against spermatozoa, medical or surgical sterilisation and medical or surgical abortion.

Artificial contraception depends upon one of two possible methods:-

- (1) A derangement of the act of intercourse, e.g., by the use of condoms etc.
- (2) A biological derangement of either the male or the female, so that the normal act of intercourse fails to cause conception, or effects abortion following conception.

Any method which prevents the continuation of pregnancy after conception is not strictly a "contraceptive" method at all; however sterilisation and abortion are also techniques which depend basically upon a physical disruption.

It is my view, as a matter of common sense, that artificial contraception, sterilisation and abortion will always prove to be physically harmful. There is available in the biological order the opportunity to regulate births, and it is the pursuit of this knowledge which should be the fundamental aim of all family planning programmes.

In the early years of our work we used the Rhythm Method, in which calculations based on observed variations in cycle length are used in an effort to predict the disposition of fertile days in subsequent cycles. Later the Temperature Method was introduced, and a combination of temperature and rhythm. All of these methods have serious weaknesses, and have no real hope of widespread application in the developing countries. Our own studies were directed to the elucidation of a technique which would give reliable warning of the approach of ovulation as well as an indication of its occurrence and in this we were attracted to a study of the

cervical mucus symptoms. We were assisted by certain distinguished medical research scientists, notably Professor J.B. Brown of the Melbourne University Department of Obstetrics and Gynaecology at the Royal Women's Hospital, Melbourne and Dr. Henry Burger, Executive Director of the Medical Research Centre, Prince Henry's Hospital, Melbourne in the Department of Medicine of Monash University. Our clinical and laboratory studies resulted in the definition of the Ovulation Method and its subsequent refinement.

The Ovulation Method is based upon the fact of the occurrence of fertility in a woman is always accompanied by the secretion of a particular type of mucus from the glands of the cervix uteri. Every woman who is capable of bearing children is familiar with this symptom, though few have previously understood its significance. There is a mounting body of evidence from both human and animal studies that fertility in the woman depends not only upon ovulation but also upon the presence of a satisfactory mucus which assists conception. The evidence includes studies of infertile women, fluctuations in fertility including the decrease in fertility with age, the influence of certain steroid chemicals such as the "mini-pill", observations of sperm survival time, sperm transport etc.

By chemical monitoring of menstrual cycles, with measurements of pituitary and ovarian hormones the scientific foundation of the ovulation method is firmly established. The account which was published in the *Lancet* (*Lancet* 1972, 1, 282) is a small proportion of a vast volume of work which has extended over many years and involved hundreds of women and several thousand investigations. Subsequently the Ovulation Method was subjected to clinical trial in the islands of Tonga in the Pacific in circumstances where it had been freely predicted that a natural method could not hope to succeed. The success of the method was the subject of a further *Lancet* article (*Lancet* 1972 11, 873).

There is now world-wide interest in the Ovulation Method and there has been considerable research into the most satisfactory organisation of teaching. One outstanding advantage is that when a woman has learned it she can teach it to other women, while the application does not require prolonged supervision. The saving in medical manpower could be inestimable, once co-ordinated teaching programmes were organised. We have found by practical experience that women make the best teachers, and that it is not necessary for the woman to have had medical training. Men are at a disadvantage as teachers because they have no first hand experience of the symptoms, for which even the observations of a gynaecological examination are a poor substitute. The practical details can be found in the references which accompany this submission.

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Amongst the advantages of the Ovulation Method are its capacity to help those married couples with apparent infertility to achieve pregnancy, by directing attention to the most fertile day of any fertile cycles which occur, in time for the information to be used to advantage. The knowledge that the method can be used in this way greatly increased interest in it, and makes it much more readily acceptable, especially in the developing countries.

Another advantage is that by teaching a woman her ~~normal~~ physiology she will always appreciate the possibility of pregnancy if intercourse occurs at a particular time; armed with this knowledge she will need no other provision to protect her from an unwanted pregnancy.

The Ovulation Method is specific, having reference not only to ovulation but also to the physiological phenomena critical to the achievements of conception. It does not depend at all upon regularity of the menstrual cycles. It is able to be understood and applied successfully by women of a low standard of intelligence and education. It is inexpensive to teach and to use, women readily learning to teach it to one another.

Another consideration which explains the acceptability of the Ovulation Method is that the need for a short period of abstinence in its application provides security to a marriage by demonstrating the capacity of each partner to control the sexual inclination for the sake of the other partner and for the good of the family.

The only criticism of the Ovulation Method and other natural methods which warrants serious consideration is the criticism is that the husband and wife remain free at all time to discontinue the use of the method, or to become careless in its application. Some demographers would even have us count ^{any} pregnancies which result from this freedom of decision as "failures". They are of course not failures of any kind, and the occurrence of these pregnancies will remain as a guarantee of a fundamental freedom which will ensure a high level of acceptance and a high continuation rate in those populations amongst which effective teaching is provided.

Our practical ^{experience} ~~teaching~~ both in Australia and overseas highlights one essential ingredient of the teaching programme. It is that the teaching of the Ovulation Method be completely separated from the teaching of other methods of contraception. Only those people who are dedicated to the success of natural methods proved to be successful teachers, and what has been called the "cafeteria" attitude is to be deprecated in the individual teacher.

John B. Billings
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The idea of the ovulation method

Evelyn L. Billings and John J. Billings

● **OVERVIEW.** This article explains the principles of the Ovulation Method of family planning and its practical use. The method is different from the Rhythm Method and the Temperature Method. The Ovulation Method does not suffer from the drawbacks of these methods and is based on the fact that the occurrence of fertility in a woman is always accompanied by the secretion of a particular type of mucus from the cervix.

There has been a considerable increase in interest in natural methods of family planning in recent years, probably for the following reasons:

1. Growing disenchantment with current methods of contraception.
2. Refinement of techniques for measurement of hormonal levels in blood and urine, to provide verification of the natural indications of fertility.
3. The somewhat belated acknowledgement of the fact that there are millions of individuals who will never use any but a natural method of family planning.

Problems of rapid population growth, especially in areas where economic resources are limited, are a reason for assistance in the promotion of competent instruction in natural family planning. There will be even greater resistance to abortion programmes than there has been to contraception, whatever hopes some people may have for abortifacient medication, such as the prostaglandins.

It is certainly desirable that all medical practitioners be reliably informed about techniques of natural family planning. They will ordinarily be consulted by people of many different religions and varying opinions on morality, and will have respect for the conscience of their clients as they will expect others to have respect for their own. It is also important for them to be well-informed on this subject, so that they will not lose credibility in other areas in which their opinion and advice may be sought.

The natural methods of family planning depend upon the biological fact that women are not constantly fertile. In fact, even when allowance is made for the

survival of the husband's sperm cells within the wife's body, it is certain that the act of sexual union on a majority of days in each menstrual cycle cannot cause conception. The use of only the infertile days for the expression of love in the sexual relationship will therefore enable pregnancy to be avoided; the use of drugs and instruments is avoided, and the act of intercourse itself is normal.

It is the occurrence of ovulation which determines the disposition of the fertile days within the menstrual cycle. Earlier fears of separate episodes of ovulation on different days within the cycle have been without substance, and it is now known that even should multiple ovulation occur, these ovulations occur in close proximity; there is only one *ovulation day* in each cycle. It is also known that ovulation results from a complex series of events involving a delicate balance between the hypothalamus, the pituitary gland and the ovaries, and that ovulation cannot occur unexpectedly; thus, for example, it cannot be precipitated by emotional shock or the sexual relationship.

Earlier natural methods

The Rhythm Method. For many years an attempt was made to predict the location of ovulation within the menstrual cycle, by calculations based on observed variations in the cycle length of the particular woman. This was the Rhythm Method. Many people found that the Rhythm Method solved the problems they had encountered in the regulation of births, and a number of the reported failures of the Rhythm Method were the result of inaccurate teaching or faulty application. However, the Rhythm Method has certain inescapable weaknesses. Most obvious of all is the need for the length of the menstrual cycles to remain within the range on which the predictions have been based. Allowance for wide variation makes the method unduly restrictive of the freedom for sexual intercourse, and in any case can provide only for limited irregularity. Theoretically, the problem could be solved either by imposing regularity upon the woman by medication, or by abandoning the Rhythm Method in favour of one which does not require regularity; the former has been attempted without success, and is obviously undesirable in that it is likely to require the continuing medication of healthy women over many years.

Another problem of the Rhythm Method arises from the fact that uterine bleeding may occur in association with ovulation, and be mistaken for menstrual bleeding. Needless to say, such a mistaken interpreta-

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tion of the significance of the bleeding could lead to the use of days for intercourse at the most fertile time of the cycle, even though the intention had been to avoid pregnancy. Another problem is that during lactation ovulation may resume before any menstrual bleeding has occurred; in such a case there would have been no reference point in relationship to which days of possible fertility could have been anticipated.

The Temperature Method. The introduction of the Temperature Method marked an advance in natural family planning because the Temperature Method has its reference to the occurrence of ovulation. The method depends upon the usual happening of an elevation of the body temperature following ovulation, i.e., the record of daily temperatures defines, and can only define, days of infertility in the post-ovulatory phase of the cycle.

Like the Rhythm Method, the Temperature Method has been of notable service to many married people. Again, however, it has inescapable defects which must be recognised so that rational efforts can be made to overcome them. These defects include the lack of specificity of the body temperature, which is subject to disturbance by influences which have no connection with ovulation. Experience has shown that the time relationship of the shift of temperature to a higher level and ovulation is imprecise, the rise of temperature sometimes occurring before ovulation, or sometimes not until several days after ovulation; occasionally ovulation is not reflected in the temperature record at all. The taking of the temperature, the reading of the level accurately, the keeping of the record and its interpretation all admit the possibility of error and discouragement. These considerations, with the expense and the need for continuing supervision, especially in those communities where illiteracy exists, and amongst the less intelligent women of all communities, provide such logistic problems as to make the widespread application of the Temperature Method impracticable. It is particularly in those communities of developing countries of the world which have the greatest need that a simpler method is required.

Most important of all, however, in the general considerations of the deficiencies of the Temperature Method is the fact that it gives no information about the approach of ovulation. It fails to define the infertility of anovular cycles, which all women experience from time to time. Many of the most anxious women requiring help are those approaching the menopause; at this time it is common for ovulation to occur very irregularly, both ovulatory and anovular cycles are encountered, and there is considerable variation in the length of the cycles; in these circumstances the temperature record provides little or no information, and is a source of frustration and disappointment.

During lactation there may be a resumption of ovulation, with return of fertility, without the warning of menstrual bleeding beforehand, as has been mentioned above. Knowledge of this has caused many exponents of the Temperature Method to persuade the mothers to wean the babies, in the hope that ovulation will soon occur. It can be objected that not only does this expectation prove to be unfulfilled in many cases, but also it is regrettable that a method should be recommended which results in the denial to the child of the nourishment best suited to its needs.

● Difficulties have been encountered with the Rhythm Method and the Temperature Method which make these methods unsatisfactory for many. The Ovulation Method however is suitable for all women. It depends upon observations of the quality and quantity of cervical mucus during the cycle.

Following menstruation, most women have dry days without mucus, which are safe days; then several days when a sticky, cloudy mucus is seen after which clear, slippery mucus occurs. Ovulation takes place just after the last day on which this clear slippery mucus occurs and if intercourse is avoided during the time mucus is present and three days after the disappearance of clear slippery mucus, pregnancy can be avoided.

The ovulation method

The considerations set out above have led to the development and subsequent refinement of the Ovulation Method,^{1,4,5} which is based on the fact that the occurrence of fertility in a woman is always accompanied by the secretion of a particular type of mucus from the glands of the cervix^{2,3}. This observation is not new; in fact it was a search of the scientific literature for a satisfactory marker for ovulation that led to its adoption as a matter for study, and we acknowledge the important scientific studies which preceded our own work. Additionally, however, it became evident on enquiry that the presence of this mucus is apparent to women themselves, the observation of the physiological symptom is commonplace.

If a man is to make a success of teaching the Ovulation Method he will have to remember that he is describing a symptom.⁵ Lacking first-hand knowledge he will need to learn the patterns of description which women use and which they understand. If he does this, he will be surprised to find that 9 women out of 10 after hearing an accurate description of the symptom for the first time will be able to record the details of a cycle correctly and that it will only be the re-

mainder who require more painstaking instruction and encouragement. A woman can commence charting immediately, taking the cycle at whatever point she is for the moment located and following it through to the menstrual period. It is recommended that she chart a cycle without any sexual contact in the first instance, so that she will not be confused by the effect of intercourse; with experience of the normal symptom no confusion will occur in the future.

In the teaching it is worthy of emphasis that all women have infertile cycles from time to time, when the normal ovulatory pattern of mucus will not occur. The amount of mucus varies from woman to woman, and the time of the maximum secretion is not to be regarded as the time of maximum fertility. There should be concentration upon the appearance of the mucus, and what is more important, the physical sensations produced by its presence and by its absence. Thus, a fertile menstrual cycle can be described in the following way:—

1. The menstrual period.
2. The "dry days" which will occur after the cessation of the period, provided that the cycle is not unusually short, with an early ovulation. The dry days are recognised by a positive sensation of dryness of the vulva. Needless to say, the interior of the vagina is always moist, and self-examination of the vagina is not required nor advised.
3. The mucus days. Commencement of the mucus is recognised by the disappearance of the sensation of dryness. Within a day or so the mucus is sufficient in amount to be seen, and at this stage will be observed to be cloudy, white or yellow, and to have a sticky consistency.
4. As the time of ovulation approaches the mucus becomes more transparent, and elastic so that it will stretch without breaking (the *spinnbarkeit*). As the symptom reaches its peak, the mucus will produce a definite lubricative sensation which the woman will notice in the course of her normal activities; at this stage the mucus is slippery and facilitates intercourse. Sometimes this "raw egg-white" mucus persists for two or three days and the last of these days is recorded as the peak. On subsequent days the mucus reverts to its cloudy and sticky characteristics. The peak symptom has been shown to occur approximately 0.9 days before ovulation, and marks the day of maximum fertility in the cycle, a practical point which can be very useful to those couples who have had difficulty in achieving pregnancy.²
5. The interval of about two weeks which elapses between the peak symptom and the subsequent menstrual period. In some cases the mucus persists or recurs during these days, but has the "non-fertile"

attributes of cloudiness and stickiness; it is not long before a woman will know that this mucus is nothing like the mucus indicating possible fertility.

● The effective use of the Ovulation Method depends upon the careful teaching of the 'mucus symptom'. Women usually do this better than men. Literature and diagrams are available from family planning clinics.

During the past two years we have made a careful study of teaching methods and believe that there are two essentials for success:—

(1) The intimate detail of the mucus symptom is to be taught by the women themselves to one another.

(2) The woman under instruction must keep a daily record of the cycle, marking at the end of each day whether it has been a day of the period, a dry day or a mucus day. This record must be kept completely separate from any other record such as that of the temperature. We have adopted a technique which was devised in Latin America using a leaflet and tiny coloured stamps, red for the period, green for dry days, and white stamps bearing the imprint of a baby for mucus days.³ The daily record not only trains the woman in the interpretation of her own pattern, it provides a visual record which enables the teacher to appreciate at once how well the woman has understood the instruction.

Confirmation of the recognition of the peak symptom is provided by the occurrence of the menstrual period approximately two weeks later. **Thereafter the dry days before ovulation, and every day from the fourth past the peak until the end of the cycle will be known to be infertile days** (See Figure 1).

The application of the method

Our recent studies in Melbourne have included two groups who had previously presented difficult problems, that of women approaching the menopause, and that of women who have been anxious to breast-feed their infants. The Ovulation Method has proved to be successful in both these groups and the results are being reported. The Family Planning Clinic in the Department of Community Medicine at St. Vincent's Hospital, Melbourne and similar clinics in Sydney are concentrating on the training of women to become teachers of the method. Already a number of teachers from developing countries have been trained and the application of the method in the islands of Tonga has been the subject of a special report.⁴

The fallacy that a combination of the natural various methods offers greater security than the Ovulation

The idea of the ovulation method

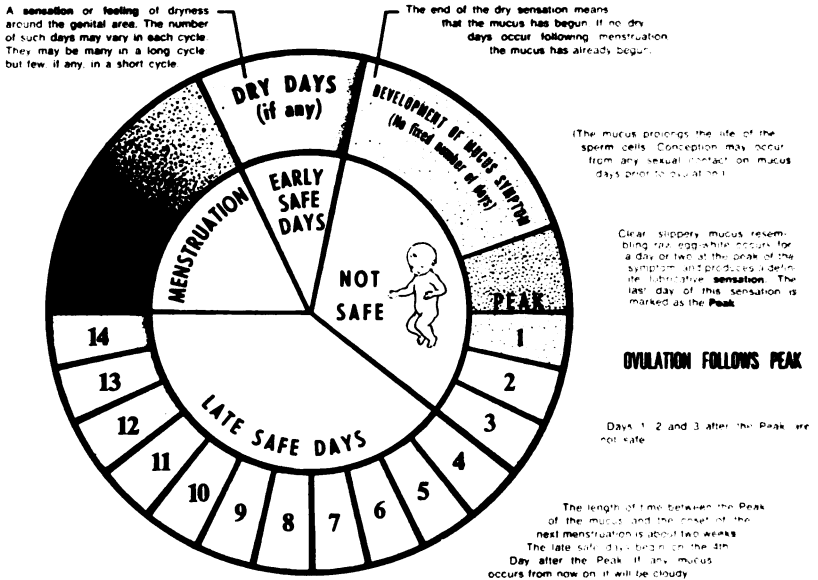


Figure 1. The safe period based on the mucus symptom.

Method alone must be repudiated. The Ovulation Method is applicable throughout the reproduction period of life, in all circumstances. To submit it to the judgement of the temperature record would be to reduce it to a post-ovulatory technique and thus prevent the solution of the problems of long cycles, anovular cycles, breast feeding, the pre-menopausal years and so on. Furthermore practical experience over many years has shown that the "combined methods" become the Temperature Method, and confidence in the mucus symptom is never established because the teaching of the symptom tends to be completely inadequate. The idea of checking one method with the other proves to impose a handicap, a "check" indeed, but in the other sense of the word.

One of the gratifying results that has been obtained has been the willingness of the husbands to co-operate. There are a number of reasons for this, an important one being the appreciation by the husbands

that their wives understand the method very well and feel secure in its use. Uneducated people, people living in poverty, even women who are unintelligent can use the method successfully.

● **SUMMARY.** This paper describes and advocates the Ovulation Method which has been shown to be satisfactory for all women because its implementation depends upon the observation of the mucus symptom which is related directly to the occurrence of ovulation. The ovulation date can be determined with ease and if intercourse is avoided during the days on which mucus occurs and for three days after the peak of the mucus symptom, pregnancy can be avoided. The need for adequate instruction in this method is stressed.

Acknowledgement

The scientific work which has provided the chemical monitoring of menstrual cycles by estimations of ovarian hormones, involving now several hundred cases, and more recently the estimation of the gonadotrophic hormones as well, has been supported from the fertility project research fund at St. Vincent's Hospital, Melbourne, supported by anonymous donors.

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United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

June 5, 1973

Honorable Caspar W. Weinberger
 Secretary
 Department of Health, Education,
 and Welfare
 330 Independence Ave., S.W.
 Washington, D. C. 20201

Dear Cap:

During hearings on S. 1708, the proposed "Family Planning Services and Population Research Amendments of 1973", a number of suggestions were made to amend section 1008 of the Public Health Service Act--which currently prohibits the use of title X funds in programs where abortion is a method of family planning--as follows: to prohibit abortion referral and counseling; and to prohibit sterilization procedures in programs supported by funds from title X.

These suggestions were referred to the American Law Division of the Library of Congress asking for an opinion on the constitutionality of such amendments in view of the Supreme Court abortion ruling earlier this year.

Attached is a copy of the response from the American Law Division. I would appreciate the Department's comments on this analysis, including a legal opinion from the H.E.W. General Counsel.

With best wishes,

Sincerely,

Alan Cranston
 Chairman
 Special Subcommittee on
 Human Resources

Enclosure

COPY



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Congressional Research Service

WASHINGTON, D.C. 20540

May 17, 1973

To: Labor and Public Welfare Committee
Attention: Ms. Ringwalt

From: American Law Division

Subject: Constitutionality of Proposed Amendment to Title X of
the Public Health Service Act (84 Stat. 1506)(42 U.S.C.
§300a-6) so as to Prohibit Abortion Referral and Counseling.

This will refer to your inquiry of May 11, 1973, relative to the above subject. Specifically, you ask us for our analysis of the constitutionality of a proposed amendment to that portion of Title X of the Public Health Service Act which currently appears at 42 U.S.C. §300a-6 and reads as follows:

§300a-6. Prohibition against funding programs using abortion as family planning method.

None of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning. (July 1, 1944, ch. 373, Title X, § 1008, as added Dec. 24, 1970, Pub. L. 91-672, § 6(c), 84 Stat. 1509.)

As we understand your inquiry, the proposed amendment to the above provision would prohibit the use of federal funds to support abortion referral and counseling. We now provide our analysis of the constitutionality of such amendment.

It is well settled that Congress may reasonably condition the receipt of federal monies. "[B]eyond challenge is the power of the Federal Government to impose reasonable conditions on the use of federal funds, federal property, and federal privileges." Ivanhoe Irrigation District v. McCracken, 357 U.S. 275, 295 (1958); See also Oklahoma v. Civil Service Commission, 330 U.S. 127, 143 (1947) and King v. Smith, 392 U.S. 309, 333 n. 34 (1968). Thus, "unless barred by some controlling constitutional prohibition", King v. Smith, *supra*, a condition restricting the use of federal monies so as to exclude the funding of abortion referral and counseling appears valid.

It may be, however, in light of the abortion decisions of the United States Supreme Court in Roe v. Wade, 93 S. Ct. 705 (1973) and Doe v. Bolton, 93 S. Ct. 739 (1973), that such a condition, as proffered in the proposed amendment, is constitutionally suspect. That is to say, inasmuch as a woman now enjoys a right of privacy which "is broad enough to encompass [the] decision whether or not to terminate her pregnancy", 93 S. Ct. 727, it may be argued that to deny her access to abortion referral and counseling limits that right and abridges the constitutionally protected decision "whether to bear an unwanted child", Roe v. Wade, 93 S. Ct. 756, 759 (Douglas, J., concurring); compare Eisenstadt v. Baird, 405 U.S. 438, 453 (1972), as well as the right, in conjunction therewith, "to care for one's health and person". 93 S. Ct. at 761 (Douglas, J., concurring). It may similarly be argued that the decision in Doe v. Bolton, striking down Georgia's statutory

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requirements that a woman seeking an abortion acquire the affirmance of authorities other than her personal physician, 93 S.Ct. 748-751, inveighs against legislatively erected impediments to the receipt of an abortion. Denying abortion referral and counseling may constitute such a prohibited impediment.

It may also be argued that the federal government, once it undertakes to fund family planning services generally, may not, consistent with equal protection principles, deny the funding, specifically, of the family planning services of abortion referral and counseling. See Harper v. Virginia Board of Education, 383 U.S. 663, 665 (1966) (once the state extends the opportunity to vote to the electorate, "lines may not be drawn which are inconsistent with the Equal Protection Clause of the Fourteenth Amendment."). With the voiding of state statutory restraints on the dissemination of birth control devices in Griswold v. Connecticut, 381 U.S. 479 (1965) and Eisenstadt v. Baird, 405 U.S. 438 (1972) and the seeming elevation of a personal abortion decision to the level of a constitutional right in Roe and Doe, it is questionable whether denying funds to abortion referral and counseling services while funding other family planning practices serves a valid state interest. As the Supreme Court in Reed v. Reed, 404 U.S. 71, 76 (1971) explained:

"A classification must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike". (Citations omitted.)

To the extent that indigent women would be deprived of otherwise available abortion counseling if such activity is excluded from funding by the proposed amendment, it may be argued that equal protection precepts are violated in that poor women are precluded by state action from receiving the same necessary abortion counseling services that are available elsewhere to women of means. In Klein v. Nassau County Medical Center, 347 F. Supp. 496 (E.D.N.Y. 1972) appeal docketed 41 U.S.L.W. 3298 (U.S. November 11, 1972)(No. 72-745) and 41 U.S.L.W. 3331 (U.S. December 12, 1972)(No. 72-803) and sub nom New York State Commissioner of Social Services v. Klein, 41 U.S.L.W. 3314 (U.S. December 5, 1972)(No. 72-770) a three-judge federal court held that a refusal of the New York State Commissioner of Social Services to include "elective abortions not medically indicated" within the scope of those medical practices funded by "Medicaid", "den[ie]d indigent women the equal protection of the laws to which they are constitutionally entitled." 347 F. Supp. 500. Commenting on the disparity in services available to rich and poor women, the court noted.

...other women, able to afford the medical cost of either a justifiable abortifacient act or full term child birth, have complete freedom to make the choice in the light of the manifold of considerations directly relevant to the problem uninhibited by state action.

Id. While Klein admittedly involved different facts including administrative action and an element of statutory interpretation, the issues involved, namely, the constitutionally fatal practice of non-funding

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abortions in Klein and the question of the non-funding of abortion referral and counseling are not, arguably, unrelated.

As a final position, one may argue that the failure to fund abortion referral and counseling "contract[s] the spectrum of available knowledge" in a manner prohibited by the First Amendment, Griswold v. Connecticut, 381 U.S. 479, 482 (1965), thus denying a woman a similarly protected "right to receive" information of a fundamental interest. *Id.* Similar information was found protected by the First Amendment in Atlanta Cooperative News Project v. United States Postal Service, 350 F. Supp. 234 (N.D. Ga. 1972) where a three-judge federal court declared 39 U.S.C. §3001 (a) unconstitutional to the extent that it rendered non-mailable information

...where or by whom any act or operation of any kind for the procuring or producing of abortion will be done or performed, or how or by what means abortion may be produced...

350 F. Supp. 239. See also Mitchell Family Planning Inc. v. City of Royal Oak, 335 F. Supp. 738 (E.D. Mich. 1972) (District Court invalidating on First Amendment grounds, a Michigan ordinance used to prohibit billboard advertisements giving information about New York abortion services); but see Bigelow v. Commonwealth, 213 Va. 191, 191 S.E. 2d 173 (1972) appeal docketed 41 U.S.L.W. 3378 (U.S. January 1, 1973) (No. 72-932) (State Supreme Court upholding state criminal prohibition against providing information to "encourage or prompt the procuring of abortion.")

CRS-6

In summary, it may be anticipated that oponents of the proposed amendment may subject it to constitutional attack on a variety of grounds, including that it acts (1) as an infringement of the abortion rights assertedly enunciated in Roe v. Wade and Doe v. Bolton, (2) as a violation of equal protection principles and (3) as an infringement of the First Amendment. In the absence of prior judicial decisions precisely on point, we intimate no opinion as to the success or failure of any of these approaches.

We do note, however, that by the proposed amendment, Congress neither (1) prohibits a woman from receiving an abortion nor (2) prohibits the receipt, by alternative means, of abortion referral and counseling. We also note that the Supreme Court took care to explain that its decision did not give a pregnant woman "an absolute constitutional right to an abortion on her demand." Doe v. Bolton, 93 S. Ct. 739, 746 (1973); see also Roe v. Wade, 93 S. Ct. 755, 756 (1973) (Burger, C.J., concurring).

In light of the fact that Congress, by the amendment, does not appear to be overtly and directly limiting the abortion decision and the fact that it does not appear that a woman, as yet, has an unqualified constitutional right to an abortion, and, presumably, abortion referral services, therefore it may very well be that the proposed amendment is not unconstitutional, but merely a legitimate condition to the receipt of federal funds.

CRS-7

The ultimate question, however, remains for the courts to decide.

If we can be of any further assistance, please call.

John D. Sargent
John D. Sargent
Legislative Attorney



THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

JUN 25 1973

Honorable Alan Cranston
Chairman
Special Subcommittee on Human Resources 2.
Committee on Labor and Public Welfare
United States Senate
Washington, D. C. 20510

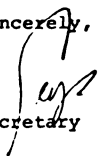
Dear Alan:

Just a brief note to tell you I have received your letter of June 5 enclosing a copy of the opinion of the American Law Division of the Library of Congress on suggested amendments to section 1008 of the Public Health Service Act.

I have sent copies of your letter and enclosure to the Office of the General Counsel for review and comment. As soon as the opinion has been analyzed thoroughly, I will be in touch with you again.

With best regards,

Sincerely,


Secretary

HARRISON A. WILLIAMS, JR., N.J., CHAIRMAN

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ROBERT E. HAGLE, GENERAL COUNSEL

United States Senate

COMMITTEE ON
LABOR AND PUBLIC WELFARE
WASHINGTON, D.C. 20510

June 27, 1973

Dr. John A. Hannah
Administrator
Agency for International Development
2801 New Mexico Avenue, N.W.
Washington, D.C. 20007

Dear Dr. Hannah:

Subsequent to hearings before the Special Subcommittee on Human Resources on S. 1708, the proposed "Family Planning Services and Population Research Act Amendments of 1973", Mr. John Short, Publisher of Triumph, sent me the attached letter raising several questions about programs administered by AID in the area of family planning services and information.

I would be very grateful if you would provide me with a report on the matters pertaining to AID raised in Mr. Short's letter.

Thank you very much for your cooperation with the Subcommittee.

Sincerely,

Alan Cranston

cc: The Honorable J.W. Fulbright
Chairman
Foreign Relations Committee
United States Senate

Enclosure

COPY

HARRISON A. WILLIAMS, JR., N.J., CHAIRMAN
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 ROBERT E. HAGLE, GENERAL COUNSEL

United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

June 11, 1973

Mr. Lester Jayson, Director
 Congressional Research Service
 Library of Congress
 Washington, D.C. 20510

Dear Mr. Jayson:

During presentation of attached testimony by Mr. John Short in hearings before the Special Subcommittee on Human Resources, Mr. Short asked for a legal opinion of the issues raised in his testimony. In addition, Mr. Short followed up on this in a May 29th letter, a copy of which is attached. We have discussed this request with Mr. Jack Sargent of the American Law Division.

Please let us have your comments on these matters as soon as possible.

Sincerely,

Jonathan R. Steinberg
 Counsel
 Special Subcommittee on
 Human Resources

Enclosure

COPY

Triumph

A PUBLICATION OF
THE SOCIETY FOR THE CHRISTIAN COMMONWEALTH
278 Broadview Avenue | (703) 347-4700
Warrenton, Va. 22186 | Cable: TRIMAC

May 29, 1973

Senator Alan Cranston, Chairman
Subcommittee - Human Resources
U. S. Senate
Washington, D. C. 20510

Dear Senator Cranston:

At the most recent hearings on the Senate Bill 1708 you ignored completely my question concerning "Doesn't any and all legislation relating to performance of the marital act violate the absolute right of privacy enunciated by the Supreme Court, as well as violate the additional constitutional protection of separation of Church and state which right and protection prohibits the state from legislating concerning private decisions which are based on religious beliefs and convictions and a right conscience in application of these beliefs?" In addition, Dr. Helman of the Department of Health, Education and Welfare dismissed as hodge-podge any and all complaints concerning the violation of the existing law which we acknowledge is presently considered to be legal even though it is unconstitutional. Furthermore, Dr. Helman extolled the virtues of A.I.D. whom I consider to be a most serious violator of the law and request an immediate investigation and reply to the following two items:

(1) The details concerning the published report that the A.I.D. mission in Panama ordered 10,000 copies of a comic book called "Los Supermachos" which violates not only the right of privacy and the division of Church and state and the moral teachings of the Catholic Church but it attacks in a blasphemous way the doctrine and dogma of the Church, as well as exemplified in the following quote from the news article covering the distribution of this comic book by A.I.D. "The cover of the comic book looks religious. An elderly woman in a reboosa prays to a statue of the Virgin Mary. Only the caption is unlike any ever printed before: "Little Virgin, you who conceived without sinning, teach me to sin without conceiving." This is the prayer of Dona Eme, heroine in one of a courageous series of popular Mexican comic books called "Los Supermachos."

(2) I would like a specific answer on your comments concerning the distribution of the abortifacient IUD by A.I.D. and your comments on Dr. Helman's remarks asking that this distribution not be interfered with.

As in my previous letter I ask that this letter be entered into the record and that I have your answers prior to June 4 so that your answers and my responses may also be entered into the record.

Sincerely yours,


John L. Short
Publisher

DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

AUG 22 1973

Honorable Alan Cranston
United States Senate
Washington, D.C. 20510

Dear Senator Cranston: —

We are pleased to respond to your inquiries relating to questions raised by Mr. John Short, Publisher of Triumph, on the procurement of 10,000 copies of a comic book, Los Supermachos, and the distribution of IUDs through the A.I.D. contraceptive program.

As you probably know, the legislation under which A.I.D. assists developing country population programs is based on three fundamental policies: (a) that these countries must determine their own population policies; (b) that they must decide what, if any, contraceptive technology must be emphasized; and (c) that A.I.D. will assist only those country programs that are entirely voluntary. In addition, the legislation is quite specific in making sure that the Agency assists only those countries where no coercion exists which would violate individual moral, philosophic, or religious beliefs. Finally, each country program must be formally requested by its government.

Los Supermachos is a weekly Spanish language comic book published in Mexico by a Mexican company. Each issue is usually devoted to a subject of current importance in Mexico and the subject is discussed with a mixture of humor, fact, and exaggeration. Several hundred thousand copies are published and sold commercially each week. This comic book is apparently widely read, especially among the lower income groups.

There was no A.I.D. involvement or financing in writing, publishing, or distributing the family planning issue of Los Supermachos in Mexico. The A.I.D. Mission in Panama

Honorable Alan Cranston

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purchased 10,000 copies of the family planning issue of Los Supermachos in November 1972 as part of that country's family planning program at a cost of \$1,100. In Panama, part of the program is concerned with developing a mass media campaign to provide a broader spectrum of the people with information concerning the opportunities to space or limit the number of children they might have, and some A.I.D. funds were set aside for information and promotion activities. At the request of the Panamanian Minister of Health, \$1,100 was spent for the comic book, presumably to reach a group of people who could not be reached by other types of printed materials. The books were turned over to the Ministry which made the actual dissemination.

I can appreciate that the cover cartoon and the inscription could well be offensive to many people. I regret very much that even this small amount of A.I.D. funds was used in connection with its dissemination. Obviously, we prefer not to play the role of censor, particularly in regard to a situation where a foreign government has asked for a publication and we are acting as the procurement intermediary between that government and a foreign publisher. Nevertheless, our procedures will be examined to minimize this kind of thing happening in the future.

In regard to the question on the IUDs, A.I.D. procures a variety of contraceptives including the IUDs upon request of host countries. Contraceptives, as with other types of assistance, are only provided to family planning programs which are voluntary.

If I can provide you with further information on this matter, please let me know.

Sincerely yours,



Matthew J. Harvey
Assistant Administrator
for Legislative Affairs

cc: Honorable J. W. Fulbright



The Library of Congress
Congressional Research Service
Washington, D.C. 20540

July 20, 1973

To: Human Resources Special Subcommittee
Attention: Jonathan Steinberg

From: American Law Division

Subject: Discussion of Legal Issues Raised in Recent Hearings Concerning
Abortion and Family Planning Practices

This will refer to your letter of inquiry dated June 11, 1973, wherein you request our legal opinion of comments addressed to the Senate Special Subcommittee on Human Resources by Mr. John L. Short, by means of testimony provided May 10, 1973, and by subsequent letter dated May 29, 1973. You enclosed with your inquiry copies of both of Mr. Short's presentations.

We trust the comments below will be of use in your analysis of Mr. Short's comments.

While the Supreme Court has enunciated a right of privacy in any number of recent decisions, see cases collected in Roe v. Wade, 93 S. Ct. 705, at 726-728 (1973), it does not appear to be the Court's position that such a right is absolute in any sense of the word. Indeed, the most recent comment by the Court in this regard affirms such a conclusion. "The Court's decisions recognizing a right of privacy also acknowledge that some state regulation in areas protected by that right

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is appropriate." Roe v. Wade, 93 S. Ct. at 727. And while the Court has extended the right of privacy to some activities relating to marriage, Loving v. Virginia, 388 U.S. 1, 12 (1967); Griswold v. Connecticut, 381 U.S. 479, 486 (1965), and family relationships, Prince v. Massachusetts, 321 U.S. 158, 166 (1944) the Court has clearly recognized that

[m]arriage, as creating the most important relation in life, as having more to do with the morals and civilization of a people than any other institution, has always been subject to the control of the legislature. That body prescribes the age at which parties may contract to marry, the procedure or form essential to constitute marriage, the duties and obligations it creates, its effects upon the property rights of both, present and prospective, and the acts which may constitute grounds for its dissolution. (Maynard v. Hill, 125 U.S. 190, 205 (1888); see also Loving v. Virginia, 388 U.S. 1, 7 (1967)).

Thus it would seem that even the fundamental right of privacy is subject to some state regulation and that the act of marriage, generally speaking, and with the exception of certain constitutionally protected intimacies, is well within the purview of justifiable legislative action.

With regard to the question of whether the First Amendment prohibits legislation concerning private decisions which are based on religious beliefs and convictions, the Supreme Court has recently held in Gillette v. United States, 401 U.S. 437 (1971) that the special statutory status accorded conscientious objection to all war, but not objection to a particular war, § 6(j) of the Military Selective Service Act of 1967, 50 U.S.C. App. § 456(j) (Supp. 1972), does not work a defacto discrimination

CRS-3

among religions, in contravention of the establishment of religion clause of the First Amendment. The Court found the following: (1) "[I]n the forum of conscience, duty to a moral power higher than the State has always been maintained," 401 U.S. at 453 (citations omitted); (2) "[I]t is hardly impermissible for Congress to attempt to accommodate free exercise values, in line with 'our happy traditions' of 'avoiding unnecessary clashes with the dictates of conscience,' Id., (citations omitted); (3) "'Neutrality' in matters of religion is not inconsistent with 'benevolence' by way of exemptions from onerous duties...so long as an exemption is tailored broadly enough that it reflects valid secular purposes." Thus, the assertion that the First Amendment does not countenance legislation concerning private decisions which are based on religious beliefs and convictions does not appear to accord with legal precedent or theory. Compare Title IV of the Health Programs Extension Act of 1973 (P.L. 93-45; June 18, 1973) (Congressional respect for those who oppose participation in abortion).

Concerning another matter, it is, at best, questionable whether State participants in the Medicaid program will be forced to provide any non-statutorily described elective surgery as a result of an affirmance of the decision in Klein v. Nassau County Medical Center, 347 F. Supp. 496 (E.D.N.Y. 1972) aff'd in part, 41 U.S.L.W. 3636 (U.S. June 5, 1973) (no. 72-745), vacated in part, 41 U.S.L.W. 3636 (U.S. June 5, 1973) (nos. 72-803, 72-770). (We enclose herewith a brief description of the Klein litigation). The issue in Klein was whether or not a State Commissioner of Social Services could, consistent with the Equal Protection Clause of the Fourteenth Amendment, elect to

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fund medically indicated abortions while refusing to fund non-medically indicated abortions. You will note that Klein concerns the fundamental personal right of abortion, Roe v. Wade, 93 S. Ct. at 726, (a constitutional status which attaches to few other, if any, surgical procedures; compare Hathaway v. Worcester City Hospital, 475 F. 2d 701, 705 (1st Cir. 1973) (sterilization)) and the authority of a state to pay for certain abortions and refuse to fund others. Klein extends no further than to the immediate questions of the surgical act of abortion. To state that Klein portends a constitutional requirement that states provide a wide range of surgical procedures, on the elective demand of the patient, that are not otherwise required as a condition of that state's participation in the Medicaid program is a conclusion not compelled by that case.

The abortion decision's holding that the word "person" as used in the Fourteenth Amendment does not include the unborn, 93 S. Ct. at 729, is advanced as partial authority for the proposition that a state may eventually compel involuntary termination of life of the aged, infirm, incompetent, and the like. Such a view ignores the established concept of constitutional personhood for those born and alive and the right to life which is "guaranteed" for such individuals by the Constitution. Cf. Roe v. Wade, 93 S. Ct. at 728. We perceive no constitutional justification for the proposition that the recent U.S. Supreme Court abortion decisions of Roe v. Wade and Doe v. Bolton portend any judicial support for "genocide" as implied by spokesmen for certain groups.

Without analyzing the informed judicial findings of Justice Harnett, based, as they must have been, on factual presentations of which

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we are unaware, we note the following New York statutory provision,
appearing at N.Y. Civ. Rights Laws § 79-1 (McKinney Supp. 1972):

§ 79-1. Discrimination against person who refuses to perform certain act prohibited

1. When the performing of an abortion on a human being or assisting thereto is contrary to the conscience or religious beliefs of any person, he may refuse to perform or assist in such abortion by filing a prior written refusal setting forth the reasons therefor with the appropriate and responsible hospital, person, firm, corporation or association, and no such hospital, person, firm, corporation or association shall discriminate against the person so refusing to act.

A violation of the provisions of this section shall constitute a misdemeanor.

2. No civil action for negligence or malpractice shall be maintained against a person so refusing to act based on such refusal.

Added L.1971, c. 1098, eff. Sept. 1, 1971.

Various other matters raised by Mr. Short's testimony are in the realm of personal opinion and, therefore, not susceptible of legal analysis.

We hope that the above information will assist you in your response to

Mr. Short.


John D. Sargent
Legislative Attorney

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United States Senate

COMMITTEE ON
LABOR AND PUBLIC WELFARE
WASHINGTON, D.C. 20510

June 27, 1973

Mr. McGeorge Bundy
President
The Ford Foundation
320 East 43rd Street
New York, New York 10017

Dear Mr.:

Thanks so much for advising me of the Ford Foundation grant to Professor Sawyer's research and training program at the University of California, Los Angeles. Needless to say, I am delighted to know he has received this recognition.

As Chairman of the Special Subcommittee on Human Resources, I have introduced S. 1708, a bill which extends the Family Planning Services and Population Research Act of 1970, P.L. 91-572. Included in this proposed legislation are organizational changes at the Department of Health, Education and Welfare, which would give much greater visibility to family planning and population research programs, as well as provide greater coordination of activities in these areas.

In the field of research, S. 1708 would establish a new advisory council to exercise peer review over grants and awards made for research programs, and to be responsible to a newly created Assistant Secretary for Population Affairs.

I enclose a copy of my remarks on introducing the legislation for your information. Any comments you care to make would, of course, be very welcome.

The Special Subcommittee on Human Resources has recently completed hearings on this legislation during which the question of the amount of financial support which can

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United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

Bundy, Mr. McGeorge -
 Page two
 June 27, 1973

be effectively utilized in the research community was discussed.

Since your organization is a major source of funding in the area of population research, it would be most helpful to the Subcommittee if you could make available to the Subcommittee information showing the amount of support provided each year by your Foundation in the past, as well as estimates of the annual support that the Foundation plans to provide in the next three years for research into contraceptive development, human reproduction, and the provision of family planning services.

This information would be extremely useful to the Subcommittee in determining the level of funding which must be provided from Federal Resources.

Thank you very much for your cooperation with the Subcommittee.

With best wishes,

Sincerely,

Alan Cranston
 Chairman
 Special Subcommittee on
 Human Resources

Enclosure

COPY

THE FORD FOUNDATION
320 EAST 43RD STREET
NEW YORK, NEW YORK 10017

McGEORGE BUNDY
PRESIDENT

July 13, 1973

Dear Alan:

May I acknowledge your letter of June 27 asking for my comments on S. 1708 for information on Ford Foundation funding of population research. Having consulted with the staff of our Population office I offer the following remarks:

S. 1708 is, in our opinion, an extremely constructive piece of legislation. If it is passed and its provisions carried out, it will stimulate and buttress a United States effort in the population field which, after heartening progress over the last five years, is in danger of faltering.

We concur with all but one of the levels of funding suggested for the several phases of the progress and with the provision that an Assistant Secretary be named to head an Office of Family Planning and Population Science. We are also pleased with the provision that would establish a Center for Population Science, which we assume would have independent Institute status and, of course, a larger budget than the Center for Population Research now located within NICHD. We are disappointed, however, with the relatively modest allocations proposed for research grants and contracts. We realize that these represent a considerable increase over the present \$40 million a year provided by CPR, but as you know there is consensus within the scientific community that an optimum level in population research -- biomedical and social science -- should exceed \$200 million a year, some three times the sums now entering the field from governmental and philanthropic sources. We are delighted to see that your bill would authorize support for research training. We consider the recruitment and training of able young people vital to the productivity of any field of science and deplore the announced intention of the National Institutes of Health to phase out all training programs by 1975.

My colleagues who have followed the recent hearings before your Subcommittee were made apprehensive by suggestions that Federal funds not be used for research on drugs that are potential abortifacients or in support of service programs in which intrauterine devices are dispensed. The former prohibition would stop work on such

Hon. Alan Cranston

-2-

July 13, 1973

compounds as the prostaglandins, which have great promise potential for a whole host of medical applications. It would also be most unfortunate if Federal support for IUD programs were withdrawn, as these devices have proven to offer the best combination of safety and effectiveness of all contraceptives now available. A most likely consequence would be an increase in the incidence of induced abortion because of contraceptive failure. We are well aware, of course, that your bill contemplates neither of these steps and that you and your co-sponsors would resist any efforts to include them.

I append two tables, one giving Foundation commitments in the population field from Fiscal 1952 through Fiscal 1972, both in the United States and abroad, and the other giving estimates of Foundation expenditures for FY 1973 through FY 1975. You will notice that we have not attempted to distinguish between grants for fundamental research and training in reproductive biology and in contraceptive developments. Most of our grants support programs that encompass a variety of activities ranging from the most fundamental to the applied, with a strong emphasis on the training of young scientists. You will notice that our commitments to population are expected to decrease in the coming years. This arises from an overall decrease in Foundation spending because of financial stringencies -- including the Federal tax we now pay -- and also from the fact that substantial funds from other sources are now available for population work in the developing countries (although these funds are largely unavailable for the development of research and training in the United States and the industrialized parts of the world). Despite these reductions we continue to give very high priority to the support of efforts directed to population problems.

I hope these remarks will be helpful to you and your Subcommittee.

Sincerely,


McGeorge Bundy

Honorable Alan Cranston
Chairman
Special Subcommittee on Human Resources
United States Senate
Washington, D. C.

Table 1
Ford Foundation: Commitments in Population
FY 1952 - 1972
(\$ millions)

<u>Fiscal Year</u>	<u>Total</u>	<u>Reproductive Biology & Contraceptive Development</u>	<u>Population Problems</u>	<u>Family Planning</u>	<u>Information Dissemination</u>	<u>Other</u>
1952	0.1				0.1	
1953	0					
1954	0.6		0.6			
1955	*				*	
1956	0					
1957	1.0	0.5	0.5			
1958	0.3	0.1			0.2	
1959	1.7	0.7	0.7		0.3	
1960	1.6	1.6				
1961	5.1	1.3	1.5	1.7	0.6	*
1962	3.0	2.5	0.2	0.3	*	*
1963	8.4	5.2	0.8	1.9	0.5	*
1964	13.4	5.4	5.3	2.6	*	0.1
1965	10.8	4.6	3.7	2.3	0.2	*
1966	26.4	16.8	2.9	6.2	0.5	*
1967	19.9	14.0	3.1	2.3	0.4	0.1
1968	11.8	4.3	3.3	3.7	0.5	*
1969	17.3	11.5	3.3	2.0	0.4	0.1
1970	15.1	8.0	3.7	2.4	1.0	
1971	18.2	11.6	4.2	1.9	0.5	*
1972	14.8	8.1	4.8	0.8	0.8	
Total	169.3	96.2	38.7	28.1	6.0	0.3

* under \$50,000

Table 2

Ford Foundation: Estimated Commitments in Population FY 1973 - 1975

(\$ millions)

<u>Fiscal Year</u>	<u>Total</u>	<u>Reproductive Biology & Contraceptive Development</u>	<u>Population Problems</u>	<u>Family Planning</u>	<u>Information Dissemination</u>
1973	16.3	9.3	3.6	3.1	0.3
1974	13.5	7.3	3.2	2.7	0.3
1975	13.0	6.8	3.2	2.7	0.3
Total	42.8	23.4	10.0	8.5	0.9

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United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

August 17, 1973

McGeorge Bundy
 President
 The Ford Foundation
 320 East 43rd Street
 New York, New York 10017

Dear Mac:

Thank you very much for your informative letter advising me of the extent of the Ford Foundation's commitments in support of population research. This information will be extremely useful to the Subcommittee in its consideration of legislation to extend the Family Planning Services and Population Research Act of 1970.

Would it be possible to break down the charts of commitments which you enclosed with your letter to indicate the amounts allocated in the United States and ~~the~~ amounts expended abroad?

I am deeply appreciative of your full cooperation and am delighted to know of your general support for the legislation. Your reservations, of course, will be brought to the attention of the other members of the Subcommittee.

With every good wish,

Sincerely,

Alan Cranston
 Chairman
 Special Subcommittee on
 Human Resources

COPY

HARRISON A. WILLIAMS, JR., N.J., CHAIRMAN
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 ROBERT E. HAGLE, GENERAL COUNSEL

United States Senate

COMMITTEE ON
 LABOR AND PUBLIC WELFARE
 WASHINGTON, D.C. 20510

June 27, 1973

Alan C. Barnes
 Via President
 Rockefeller Foundation
 111 50th Street
 New York, New York 10020

Dear Mr. Barnes:

As Chairman of the Special Subcommittee on Human Resources of the Labor and Public Welfare Committee, I have introduced S. 1708, legislation to extend the Family Planning Services and Population Research Act of 1970. (P.L. 91-572).

The Special Subcommittee on Human Resources has recently completed hearings on this legislation during which the question of the amount of financial support which can be effectively utilized in the research community was discussed.

Since your organization is a major source of funding in the area of population research, it would be most helpful to the Subcommittee if you could make available to the Subcommittee information showing the amount of support provided each year by your Foundation in the past, as well as estimates of the annual support that the Foundation plans to provide in the next three years for research into contraceptive development, human reproduction, and the provision of family planning services.

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LABOR AND PUBLIC WELFARE
WASHINGTON, D.C. 20510

Barnes, Mr. Alan C.
Page two
June 27, 1973

This information would be extremely useful to the Subcommittee in determining the level of funding which must be provided from Federal Resources.

Thank you very much for your cooperation with the Subcommittee.

With best wishes,

Sincerely,

Alan Cranston

Enclosure

LE:JR 6-27-73

COPY

The Rockefeller Foundation

111 WEST 50TH STREET, NEW YORK, N. Y. 10020

BIO MEDICAL SCIENCES

CABLE: ROCKFOUND, NEW YORK
TELEPHONE: COLUMBUS 3-9100

August 1, 1973

Dear Senator Cranston:

Dr. Barnes has asked me to reply to your letter of June 27, since support in the areas you specify is recommended under the Foundation's population program. There follows a listing of total grants approved each year under that program, beginning in 1963 when the program as presently defined first began.

1963	\$ 624,300
1964	\$ 2,895,500
1965	\$ 3,235,800
1966	\$ 4,016,850
1967	\$ 5,265,450
1968	\$ 4,379,100
1969	\$ 4,709,000
1970	\$ 16,341,200
1971	\$ 6,314,600
1972	\$ 6,415,300

Because of a current review of our overall program and budget situation, we are unable to provide estimates of future support; however, we expect that commitments over the next year or two will be approximately in the same range as 1971 and 1972.

Sincerely yours,

John Maier
John Maier, M.D.
Director

The Honorable Alan Cranston
Subcommittee on Human Resources
Committee on Labor and Public Welfare
United States Senate
Washington, D.C. 20510

A Statement in Support of a Senate Bill to Amend
Title X of the Public Health Service Act

John F. Kantner, Ph.D.
Professor of Population Dynamics
Johns Hopkins University

The case I wish to lay before you today might appear to be a case of special pleading coming as it does from one who earns his keep at a university department that is heavily dependent on federal monies for its existence. In addition, I have served the Center for Population Research of NICHD in a consultant capacity and am a member of its Population Research Committee. A company man for certain you may feel whose arguments will need special discounting.

I have other handicaps in appearing before you for I will be speaking in favor of research and training and, what is worse, in favor of the ugly duckling of the scientific barnyard - social science research. I hope despite these odds to persuade you on a point or two.

The bill before this committee contains a number of provisions regarding the way government activities in the domestic population field ought to be organized and specifications regarding levels of funding. The section of the bill to which I shall address myself is that which provides that the Assistant Secretary for Family Planning and Population Science, through the proposed National Center for Population Science and with due consultation "shall make grants to public or nonprofit entities and enter into contracts...for projects for research and research training...including the establishment of university-based research centers" (p. 10). To accomplish this the bill would authorize a schedule of payments increasing from \$65,000,000 in FY '74 to \$80,000,000 for the fiscal year ending June 30, 1976 (p. 11). In my judgement this is a sound and reasonable proposal and one that merits high national priority.

There is no attempt in the bill to allocate funds between different fields of research and indeed, in my opinion, it would be unwise to do so. The Director of the National Center and his staff with advice from their various advisory groups are the ones best equipped to decide what areas of investigation are apt to be most fruitful and what types of research expenditure appear likely to have the greatest impact. This freedom with respect to research strategy should extend also in my view to decisions regarding modes of research funding: grants, contracts or in-house activities. In short, I ask for no protectionist provisions for social science research nor for that mode of funding so beloved by university investigators - the research grant. Among professionals who deal daily with the population problem in its different guises the essentiality of the contributions of the medical researcher, the clinician, the bench lab scientist, the social scientist - and in these days the systems engineer, the marketing specialists, the lawyer and

others - are accorded due mutual recognition. The same is true of the importance of both basic research and of applied or, as they like to say in Washington, goal oriented research. All of these fields and modes of approach have their proper place in attacking the problems we group together as the "population problem".

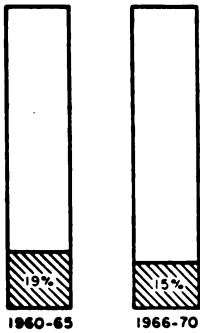
Before turning to the task of supporting the provision of the bill calling for social science research and research training, I should like to speak briefly to a point that comes up frequently when population is discussed these days - that is our currently low birth rate. It would seem perfectly reasonable to ask why the nation's tax revenues should be spent to study a problem which seems about to vanish. Overlooking the possibility that we may one day become anxious over low fertility and follow Germany, Japan and other nations in calling for research on the causes and implications of a low birth rate, there still are compelling reasons why we must continue to keep the population problem under scientific surveillance. For one thing we are not sure why the birth rate has fallen to its present levels. New methods of contraception may have had something to do with it but that is entirely too facile an explanation. Trends in fertility are more dependent on social and economic conditions as translated into individual motivation than on modes of birth control. We're in about the same situation in predicting the future course of fertility as the stock market analyst is in charting the present market. The fundamentals are right for a rise in the birth rate but we appear to have bottomed. The point is we don't know what is happening. It could, and some think might, go the other way when young Americans turn bullish on marriage and family building. Many social scientists feel, however, that the most likely prediction about the course of future fertility in this country is that it will be the fluctuating kind we have seen the recent past with peaks and troughs every 15 to 20 years. This sort of thing keeps journalists, sociologists and other professional seers and chroniclers busy but is probably not good for the country otherwise. Such demographic fluctuation has a whipsaw effect that is felt throughout the society and is manifest in the present period for example by surplus capacity in parts of our educational plant, in unused facilities for maternity and pediatric care and, farther along on the age continuum, in unemployed youth, in crowded jails and in a socially divisive youth culture that is in part a response to the demographic uniqueness of the high birth cohorts of the postwar years. Our institutions of national life and perhaps also our economic and social system perform better under conditions of stability or steady measured change than under a boom and bust demographic regime.

A more tangible reason for not abandoning interest in population just because the birth rate is down is given below in the simple but eloquent chart. Despite great great advances in knowledge and technique, a large proportion of children born every year are not wanted at the time they are conceived. Some of course ultimately become wanted and loved by their parents or someone else; many do not and are battered emotionally and physically and become a source of discord among those who are re-

Fig. 3 UNWANTED FERTILITY IN THE UNITED STATES

MARITAL FERTILITY*

PERCENTAGE OF BIRTHS
REPORTED TO HAVE BEEN
UNWANTED

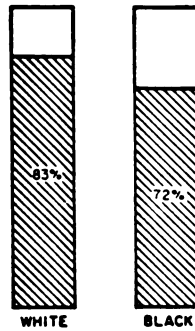


*SOURCE OF DATA: REFERENCES 12 AND 13

**SOURCE OF DATA: REFERENCE 2

**NON-MARITAL TEENAGE
PREGNANCY****

PERCENTAGE OF CURRENT
PREGNANCIES REPORTED AS
UNWANTED, BY RACE, 1971



sponsible for them. On this fact alone I could rest my case for social science research since this is a phenomenon we can describe better than explain. We have the means to prevent pregnancy. We know what the demographic effects of eliminating unwanted births would be. But we are not yet able to devise programs that would assist our people, and especially our young people, to handle this part of their lives more satisfactorily.

In arguing the case for social science research as part of a scientific assault on the problem of rapid population growth there is a more subtle problem to contend with than that presented by the current level of fertility. That is the skepticism in some quarters regarding the utility of social science research to those who make policy and implement programs. In part this skepticism is a reasonable reaction to some of the failures of the field. In considerable part, however, it is due, I believe, to a common American predilection for technological solutions, for the "technological fix." No matter how badly we are let down, our faith in technology and our belief persists as a strong strain in the average American's views of how to manage our national problems. We encounter this in all areas of national life and in the population field it has been especially seductive. Both private foundations and government agencies have staked their greatest hopes on contraceptive development. I do not wish to pursue the argument here except to argue that to solve problems such as those we face in the population field everyone's contribution is needed.

There is admittedly much that is imprecise and inelegant in the work of social scientists for they are dealing with the most complicated and intractable subject that one can imagine - human behavior. To say that someone is "only human" is ordinarily to excuse him from the rules of conduct that are expected in a given situation. We have no phrase in the physical or natural sciences that carries the same sense of dispensation, unless it might be the principle of uncertainty. At any rate human behavior is an elusive quarry and investigations in this field sometimes bag very little.

Having admitted to our deficiencies let me insist that you can't do without us. It is simply necessary in almost any area of social endeavor individual and collective to consider the human response. This point was made years ago in the famous studies of industrial production at the Hawthorne plant of Western Electric. Productivity it seemed was not the result of those dimensions of the work situation that could be engineered, such things as illumination, hours, rest periods, but of the group situation - call it the human side if you like. It has taken some sectors of American industry more than a generation to learn this lesson but that does not mean that the social scientist wasn't saying something useful.

There are few areas of knowledge in which the utility of social science research is as amply demonstrated as in the field of population.

Research of the last 10 years or so has revealed the intricate nature of population dynamics and has provided information about our population that is essential for the formation of realistic policies. While there is still much to be learned we have discovered a great deal from research. We know for example that nearly a third of married couples of reproductive age are impaired to some degree in their ability to have children; we know that even though contraception is wide spread a significant proportion of pregnancies occur when contraception is being used; we know that women of reproductive age are poorly informed about the elementary facts of their own biology; we know that the spacing of births can have a great effect on the birth rate without any change in average family size; we know that even if a two-child family were somehow to be adopted overnight, we would still have over half a century of growth in prospect; we know that our population is getting older, not because we are living longer but because fertility has been declining. We know these things, and many more, as the result of painstaking, meticulous research. Yet there are vast areas of ignorance concerning other elemental facts and relationships. For example, we still have no real understanding of the way income or education influences fertility. Similarly there are striking differences between blacks and whites in their fertility and even greater differences within the black population which we cannot explain in any fundamental sense. The effect of the wife's entry and exit from the labor force on fertility has yet to be unscrambled. The same is true of the net effect of divorce. Do the mounting divorce rates tend to dampen the birth rate or do they, since most divorces are followed by remarriage, have a net effect in the opposite direction? And what of the high rates of illegitimacy? What is responsible for their rapid rise in recent years and what is responsible for the large differences among subgroups of our population in the prevalence of illegitimacy? The list of questions related to the reproductive behavior of the American population that have obvious welfare implications can be extended. Moreover if we were to expand our view of the matter to include the movement of our people, the way we are distributed over the landscape, the environmental, economic, social and psychological effects of mobility and density, the long term implications for our political, economic and social life of current rates of growth, etc., we would have a staggering research agenda.

In an attempt to identify areas of needed research the Center for Population Research of NICHD has from time to time issued a call to the scientific community for assistance in coping with the research backlog. Among the topics on CPR's list are:

- . Strength of motivation for fertility control.
- . Attitudes toward various methods of regulating fertility.
- . Contraceptive practices of married and single individuals.
- . Access to methods of fertility control for subgroups of the population.
- . Use effectiveness of various contraceptives.
- . Fertility control and illegitimacy among young adults.

- . Attitudes toward abortion.
- . Attitudes of the "general public" and of special subgroups to population policy issues.
- . Effect of housing legislation, tax policy, food programs, etc. on population phenomena.
- . Determinants and consequences of migration and population redistribution .
- . Consequences of zero population growth.

These are all questions which an enlightened government should address. If that proposition is accepted, however there remains the question of how much of an effort is required. I know of no way to determine how many dollars should be set aside for this purpose other than to look at the current level of funding and ask if additional money could usefully be put to work. Most of the federal funds now being channeled into population research come through the Center for Population Research of NICHD. The amount available in FY '73 for noncontract social science research is approximately \$1.6 million. It may help to judge this figure by noting that the National Fertility Survey of 1970 cost over \$1 million. This was an important survey and is the basis for much of what is known about the fertility and contraceptive practice of married couples. Nevertheless it provides answers to only a few of the questions which need to be answered.

The \$1.6 million awarded in FY '73 is going to individual social scientists in the form of research grants awarded after competitive peer review. This is in addition to funds for social science research let under the Center's contract program. The total dollar value of grants approved on the basis of their scientific merit was \$5.3 million. Thus NICHD was able to fund less than 1 out of 3 of the projects which its scientific consultants declared to be worthy of support. The picture is similar if we examine the record from the point of view of the number of projects rather than their dollar value.

Social science projects approved by the Center's consultants represent about half of those (in dollar amount) received, so that in these terms, the Center is funding only 15 percent of the applications it receives. Many of the projects which are disapproved could with some tightening of design and greater specification of procedures have received approval and a number of them do on resubmission. It is clear therefore that the dollar value of approved projects is a minimal estimate of the funds that could be spent for scientifically creditable research.

The funding situation for research moreover is retrograde. The situation in FY '73 in contrast to FY '72 shows fewer projects funded, less money going into funded projects and a lower ratio of funded to approved projects:

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**Projects Funded and Approved for Social Science Research in Population
by NICHD in FY '72 and FY '73**

FY '72				FY '73			
<u>Projects Funded</u>		<u>Total Approved</u>		<u>Projects Funded</u>		<u>Total Approved</u>	
<u>No.</u>	<u>Amount</u> <u>(Millions)</u>	<u>No.</u>	<u>Amount</u> <u>(Millions)</u>	<u>No.</u>	<u>Amount</u> <u>(Millions)</u>	<u>No.</u>	<u>Amount</u> <u>(Millions)</u>
47	\$1.8	88	\$3.8	38	\$1.6	116	\$5.3

The total number of approved projects increased by 32 percent and the value of approved projects increased by 39 percent. Inflation aside, this can be taken as an indication of increased scientific attention to the social science aspects of population or to enhanced quality of applications or both. Yet the number of funded projects declined by twenty percent and the amount actually awarded for approved projects declined by around 12 percent!

The President's budget for 1974 shows no increase for research which in effect, given inflation means a further reduction in research activity. The fact that certain other divisions of NIH may be suffering greater reductions is of little comfort in the face of the clear need for more knowledge in the population field and the demonstrated readiness of the scientific community to take up the challenge. The sums are small both in absolute amount and in relation to what might be accomplished. Administration policy in this matter is, in my view, both short sighted and niggardly.

Discouraging as these figures are that I have been reviewing, they tell only part of the story. To increase our understanding of the factors that influence population trends and the consequences of such trends, the contributions of many diverse disciplines are needed. Private foundations, universities and government agencies in the last several years have directed a considerable effort toward quickening the interest in population research of professionals in fields such as psychology, economics, political science, geography, systems analysis, management - even philosophy and theology - fields which traditionally have not paid much attention to population questions. These recruitment efforts are beginning to bear fruit just at the time when opportunities are being foreclosed. The initial response of these fields is reflected to some extent in the increased number of project submissions which we have noted above. The potential commitment to this area of investigation by this new breed of investigator is not yet fully registered.

In sum the amounts available for social science research in the

population field are inadequate in relation to the magnitude and importance of the problem as well as in relation to actual and potential commitment of the scientific community. The amount that might be used effectively is hard to estimate since the mobilization of professional talent for the assault is still underway. The amounts specified in the bill appear appropriate and should provide for vigorous programs of research in basic reproductive biology, in contraceptive development, as well as in the social science aspects of the problem.

The provisions in the bill for a separate institute is not a matter on which I can make expert judgement. However the idea makes sense in view of the competing claims on the leadership of NICHD which now must be concerned with four other problem areas: mental retardation, aging, perinatal biology and child growth and development. Not only is it a large order to add population to that list of responsibilities but it is true also that population is in many respects a broader area with ramifications far beyond child health or human development. A separate institute, I should think, could more easily coordinate its activities with other institutes and other branches of the federal establishment.

Finally I should say a word about the bill's provision for research training. The administration and its agency in such matters, the OMB, has declared training grants to be unnecessary. An understandable desire to restrict federal expenditures underlies this position. It would seem that the anti-training bias is sustained also by anecdotes about physicians with inflated incomes who were trained at government expense, by an alleged surplus of trained research scientists and by a commitment to student loans rather than fellowships. The loss of federal support for population training threatens most of the programs that have been built up in recent years with the aid of private and federal money. This in itself is an enormous waste of time, talent and treasure. It is also a classic instance of bureaucratic overkill. The need for persons trained in population research has not been met, although admittedly the cut back in programs in self fulfilling fashion, has dampened slightly the market for new graduates. Professionals who work in the population field are not excessively remunerated compared to professionals in other fields. In any case the way to handle those who use their publically financed training for large personal gain is not by the elimination of federal training programs but by more astute drafting of legislation which would require repayment in such cases. A number of such remedies have been proposed.

A further point that sometimes gets lost in the debate about student loans and the demand for new Ph.D.'s is that training grants help to pay for faculty and for training facilities. Typically about half the funds of a grant will be so allocated. Phasing out training grants tends to increase the dependence of institutions and their faculties on research grants. More seriously it places a lien on our capacity to deal with these problems over the long haul. The research horizon with which we must deal in at least twenty to thirty years in my view if we recognize

- 8 -

that the nature of the problem is likely to shift in that time from a concern with fertility regulation to a concern with the problems of a nongrowing, highly compact but highly mobile population. The present generation of scholars must see to their replacements. Our priorities in such matters must be set by our needs for knowledge and for new solutions to old problems not by an unperceptive, undifferentiated rendering of budget policy.

I ask this subcommittee to give this problem its due importance and in so doing to recognize that the social scientist along with professionals from other fields is an essential member of the team.

Statement of
THE NATIONAL URBAN LEAGUE
before the
SPECIAL COMMITTEE ON HUMAN RESOURCES OF THE
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE
on
FAMILY PLANNING SERVICES AND POPULATION
RESEARCH AMENDMENTS of 1973
Washington, D.C.
May 22, 1973

The National Urban League is a professional, non-profit, non-partisan community service organization founded in 1910 to secure equal opportunity for black Americans and other minorities. It is governed by an interracial Board of Trustees and is concerned with fostering good race relations and increased understanding among all people of these United States.

It works through local affiliates in 102 cities located in 37 states and the District of Columbia, five regional offices, a Research Department and a Department of Government Affairs. These units are staffed by some 1600 persons, trained in the social sciences and related disciplines, who conduct the day-to-day activities of the organization throughout the country.

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Strengthened by the efforts of some 25,000 volunteers who bring expert knowledge and experience to the resolution of minority problems, the National Urban League is unique as the only national educational and community service agency which devotes its entire resources to the use of social work and research techniques for bettering the lives of the disadvantaged and for improving race relations.

Our family planning program is one of the League's major efforts in the health and social welfare fields and I would like to explain why. The National Urban League recognizes the responsibility of public agencies in the dissemination of family planning information and services to those who may be unaware that such methods are available to them, and has kept in mind at all times the fundamental importance of individual freedom of choice, based on personal values and religious convictions, in selecting or refusing such services. The Urban League became directly involved in family planning with the intention of trying to counteract barriers to acceptance and utilization of family planning services, and to better the quality and relevance of these services to the minority population. There is no question that the health and social welfare problems of minority groups and the poor of this country are vastly out of proportion to the health problems experienced by the majority of individuals in our society. A look at the national health

- 3 -

statistics supports this. The poor have the highest rate of infant mortality and the lowest life expectancy. The maternal death rate for black and other minority group women in 1968, for example, was about four times higher than the rates for other women. This is in part a reflection of inadequate health care through childhood and puberty, and in part a reflection of inadequate prenatal care and lack of adequate family planning services. The inequitable distribution of health care is a tragic reality which affects every neighborhood where the poor, blacks and other minorities in this country live. As a result, much of the health care most poor people receive is crisis-related, emergency care. With all of these inequities in mind, the Urban League set out to help people help themselves to better health care in general and to preventive health care in particular.

The provision of adequate family planning services is a basic preventive health care measure. A large proportion of infant mortality, mental retardation, congenital defects, prematurity, and brain damage are related to maternal health. The incidence of these conditions rises alarmingly among women having too many closely spaced births, among older women, and among first births to teenage women. The risks associated with pregnancy and childbearing are highest among the poor.

- 4 -

Maternal and child health care, dental care, TB testing, and other preventive health services assist in securing and improving the health of individuals, and comprehensive family planning services secure and protect the health of women and the future of each child.

Most Americans receive fertility-related health care under the direction and supervision of their private physicians. For the most part, poor women must depend upon public facilities and financing for their health care; sometimes they are able to obtain services through the charity of physicians. Comprehensive family planning services are needed on a regular basis and over a long period of time, and these preventive services are not often available through the traditional public or charitable mechanisms. The League believes that certain health problems of low-income families and individuals would be abolished if adequate professional health services related to pregnancy and fertility were made available to the poor immediately. The risks associated with pregnancy and childbearing are highest among the poor. We realized that poor women in this country had little chance of receiving good gynecological and contraceptive services unless we helped them by insuring the delivery of these and other preventive health services to the extent of our capability. Today, the Urban League operates seven programs in seven major cities:

San Diego, California
St. Louis, Missouri

- 5 -

Kansas City, Missouri
Miami, Florida
Chicago, Illinois
Albany, Georgia
Albany, New York

These affiliates were selected for family planning programs in an attempt to secure a variety of geographical locations which would offer the opportunity to deal with multi-faceted service problems. The National Urban League Family Planning staff provides the affiliates with technical assistance in such areas as project development, operation, managerial skills, training, advice and assistance in family planning clinic services, patient information and educational needs. These programs are also working with community groups where it is most important that people understand and monitor the health care they receive.

This brings us to a discussion of the League's federal family planning program authorized by the Family Planning Services and Population Research Act of 1970, which expires on June 30th. This program, and the comprehensive services provided by it, offers a great health care opportunity for our nation. In addition to contraceptive care, the range of health services provided by this program includes basic gynecological examinations, Pap tests, cancer detection, and VD screening. These services are provided for women who without this program might live their entire lives without ever receiving services which most Americans take for granted as essential to their well-being. Without question, programs authorized by this legislation

- 6 -

are a primary means of securing and improving the health and well-being of low-income families and individuals. According to HEW's most recent status report, these programs are now serving about two and a half million women who would otherwise have been unable to obtain family planning health care. If this legislation could be extended over the next few years, with adequate funding levels, by 1975 all of the six and a half million medically indigent women in the United States who want and need these services would be receiving them. Not only women but millions of families and children would benefit.

If this legislation is allowed to expire, I can only tell you about a typical patient of a federally subsidized family planning program. This is a young woman who has studied hard to finish high school and get her first job, thereby becoming the only gainfully employed member of her family. She depends upon that program because she can not afford a private physician and is not eligible for Medicaid. This young woman would face a shut-down clinic and the probability of an unwanted pregnancy. By cutting off family planning services to her and to the thousands of young women like her, many of these young women will be forced to bear unwanted children. I can tell you about another typical woman enrolled in a subsidized family planning clinic. She has several small children, has a job, and her husband is employed only part-time due to a lack of skills. With this family's marginal economic independence, the birth

- 7 -

of one unwanted child will force them into dependency and kill any hope they may have for gaining a better standard of living. We can not condemn these people to the poverty and suffering associated with unwanted pregnancy and childbearing. We must, instead, continue to mobilize our resources toward better health care and more equitable access to quality health care for all of our people.

As a member of a minority group, I am aware that discrimination still exists in all parts of our country and is unevenly distributed. Certain attitudes take time to die out. One of the major accomplishments of HEW family planning program is the development and delivery of services under a national standard of care. These high standards insure quality health care for every woman in this program, wherever she may live. We believe that a national program is the only safeguard against punitive attitudes in the delivery of services or punitive use of the program. Moreover, the national standards imposed by HEW insure comprehensiveness of medical care and consumer participation in every program. To illustrate this point, no specific national standards were developed for the family planning program under the Office of Economic Opportunity.

With little program direction from Washington, medical and other criteria were locally determined and, in many instances, sorely lacking. As a result, certain medical services were not provided or were decentralized with little supervision

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to guard against uneven medical care and to insure consumer participation. We believe that the monitoring of family planning programs must come from the federal government in order to make certain that local programs are accountable at the national level and that programs continue to be both comprehensive and voluntary.

The National Urban League believes that the national family planning program must continue until all persons are guaranteed freedom of choice with regard to family size and spacing of children. We believe it is the duty of the government to guarantee such freedom of choice through the provision of comprehensive family planning services to all those desiring them. We have no reason to assume that local and state governments will be either willing or able to commit the resources necessary to provide these services. The development and financing of categorical family planning programs must come from the federal government until such time as we are able to integrate family planning services into a comprehensive national health insurance program of some kind.

In addition, I would like to point to the need for much more intensive research leading toward a range of safer and more effective contraceptive methods. Our present contraceptive technology is not adequate to meet the needs of all individuals in our society. There are problems associated with our most modern methods of contraception, the IUD and the pill, and improved

- 9 -

technology is desperately needed. While we deplore compulsory testing for sickle cell trait, I must point out that sickle cell anemia is contraindicated to the use of oral contraceptives. Hypertension, which appears to have a greater incidence among blacks, also makes pill use inadvisable. These points illustrate the need for expanded research in this field.

Passage of the bill before this subcommittee, which continues and expands the Family Planning Services & Population Research Act of 1970 for three more years, is essential. Progress has been made in the last few years, progress which is basic to the achievement of our most important health goals and vital to the elimination of poverty and institutional racism from our national life. We must continue the work that we as a nation have begun.

Testimony of

Mrs. Shirley Okrent, Coordinator
Nurse-Midwifery Activity in the
Family Planning Clinics of the
Kings County Hospital Center
and
Downstate Medical Center

I am a Registered Professional Nurse and a Certified Nurse-Midwife in charge of the Family Planning Clinics at the Kings County Hospital Center and Downstate Medical Center located in the heart of the borough of Brooklyn, New York.

Although I have administrative responsibilities, most of my time is spent in giving direct service to the patients and the clinical instruction of nurse-midwife students in the techniques of performing post partum examinations and delivering family planning services.

In this report, I will try to describe the function of the nurse-midwives together with the physicians within the framework of a comprehensive maternal and child health care program. Family Planning is an integral part of this care.

The Kings County Hospital Center is both a city and county hospital with a bed capacity of close to 3000. Almost all of the patients it serves are classified as medically indigent. It is a predominantly black population comprised of Americans (from the rural areas of North and South Carolina), Haitians, West Indians, and Spanish speaking people from Puerto Rico, Mexico, Central and South America. There is a small group of Europeans, American whites, and people from Asia and the Near East.

The Downstate Medical Center, located across the street from Kings County is part of the State University of New York. This Center has its own clinic and hospital facility. Medical students obtain clinical experience in both hospitals and clinics. The same Department Chairman and Resident Physicians serve both hospitals. The University Hospital of the Downstate Medical Center accomodates both private and ward patients.

Nurse-Midwives have been a part of the obstetrical team at Kings County Hospital since 1958. As Faculty in the Division of Nurse-Midwifery, they are responsible for the training of midwives. The same faculty have service responsibility as well. Last year, the Division trained a total of 54 women in the combined Basic, Intern, and Refresher courses. In the service capacity, they delivered 39% of the obstetrical patients for a total of 1580 deliveries. In the Prenatal clinic, they managed 61% or 12,668 patient visits. In the Post Partum and Family Planning they cared for 93% or 18,677 patient visits.

What is a Nurse-Midwife? The Nurse-Midwife in the U.S. is a Registered Professional Nurse who is professionally certified in Nurse-Midwifery after additional theoretical and clinical training in obstetrical care. She is qualified to carry out the patient's prenatal examination and evaluate the course of pregnancy. She is specially trained to detect difficulties during the pregnancy and refer these to the doctor's attention. In the U.S. the nurse-midwife is never a private practitioner. The midwife and physician practice as a team; together they offer the patient more comprehensive care than either can give alone.

The midwife is a skilled specialist in normal obstetrics, qualified to manage the process of normal labor and deliver the baby exactly as the doctor would. She cares for the newborn immediately after delivery. She provides constant attention and gentle support to the woman in labor even as she exercises judgement in the management of the course of labor.

In making daily rounds on her post partum patients, she discusses post partum care of both the mother and her baby, infant

feeding, adjustments to the home situation and planning for future pregnancies. Methods of contraception are introduced on a "cafeteria" basis, it is up to the patient to choose a safe method unless there is a valid medical contraindication to that method. Contraceptive pills, condoms and spermicidal foam may be offered to the patient before she leaves the hospital. It is necessary to help the patient realize that fertility may be re-established before the first menstrual period.

Pregnant teenage girls, 16 years and younger, married or not, attend the separate Prenatal clinic conducted by Nurse-Midwives. Here in their own clinic, their special physical, emotional, social, and educational needs are sympathetically handled by experienced professionals. In addition to the midwifery staff, there is a social worker and clinical psychologist. Group "rap sessions" as well as individual guidance is available to these high risk youngsters.

The same midwives are on call for the teenagers when they are admitted to the Labor Room. If the course of their labor is normal, they will be delivered by the nurse-midwife. In the event of complications, they will be supported in labor as well as the Delivery by the midwife and the doctor will manage the delivery of the infant.

They are counselled on methods of family planning and may receive contraception before leaving the hospital. In the Post Partum Family Planning Clinic, six weeks after delivery, they are examined and given follow up birth control methods by the same midwifery staff that attended them throughout the prenatal and intrapartum period.

So often, the young girls telephone their "substitute mothers" for advice and support on home problems. Together with the social worker and/or psychologist, the midwife helps the girls make this difficult adjustment.

The Post Partum - Family Planning Clinic is staffed by 7 nurse-midwives and 3 physicians. Each week, the same staff holds four clinic sessions at one hospital and three sessions at the other. It is one of the largest clinics of its kind in the nation with a registration of over 24,000 patients.

We perform examinations, take Papinicalau smears, do routine Gonorrheal cultures, insert and remove intra-uterine devices, fit vaginal diaphragms, initiate oral contraception, arrange for voluntary sterilization for both males and females, counsel revisit patients on matters concerning contraception, personal health, diet, sexuality, child and infant care, and family life.

Each week approximately 400-450 patients receive our care and advice which includes 225 new patients. Of the new patients, 100 are post partum, 100 post abortion, and 25 are walk-ins or referrals from other clinics. The remainder are revisits.

It is not possible to keep all of the new patients as the clinic census would escalate far beyond our capacity to serve in a short time. Instead, we retain all those who are nearest to our clinic and all the patients on special research studies. The others are given initial contraception and referred to a neighborhood Family Planning Clinic. We have close liason with all 24 clinics in Brooklyn and with the community organizations in both the Brownsville - East New York and the Bedford Stuyvesant sections. Workers from these O.E.O. funded organizations, come

to our clinic each week to give the patients, assigned to their neighborhood family planning centers, direct appointments. We meet with these workers from time to time to promote better understanding between their services and ours and to discuss improvement and mutual expansion plans.

In describing the number of new visits, I made mention of the post abortion patients. At Kings County Hospital, approximately 154 elective abortions are performed each week by physicians. Four weeks later, the staff in the Post Partum family planning clinic examines those who keep the appointment and either initiates or continues a birth control method of the patient's choice. As with the other new patients, referrals are made for follow up care at their neighborhood clinics.

Each day, one of our staff, visits the abortion unit, to educate patients on the methods of contraception, to give condoms and foam, or oral contraceptives at the bedside, to counsel, support and relieve anxieties of the women who are about to undergo the operation. We explore with each woman the reasons for past failure. All efforts are bent on preventing a repeated abortion. Needless to say, we do not always succeed.

Besides the service aspects of the clinic, our staff in family planning is engaged in a vast manpower training program. Under a Grant from the Agency For International Development, three 12 week courses are held each year for foreign midwives, most of whom come from developing areas. Twelve to sixteen midwives are sent to us from various agencies such as A.I.D., Pathfinder Fund, I.P.P.F., W.H.O., and others. The trainees attend all seven clinic sessions per week and are instructed in performing all

techniques necessary to give qualitative as well as quantitative family planning services. When clinic is not in session, the course provides lectures, films, demonstrations with visual and manual aids, discussions, and field trips. Interpreters are available to those students who cannot speak or understand English.

In between the three 12 week courses for foreign midwives, we arrange shorter courses for Americans who are enrolled in the Division of Midwifery at the Downstate Medical Center. About 60 such students enrolled in the three courses offered by the School are given two weeks of intensive clinical and theoretical training in our clinic. Some very interested students come back on an individual schedule to obtain better skills. Other American Nurse-Midwives come to us from out-of-state for the three month training along with the foreign students. They must obtain their own funding. We expand our staff from this latter group and the midwifery students enrolled in the School of Midwifery. The foreign students are expected to return to their countries after training.

Third year medical students are given an opportunity to obtain instruction in three clinic sessions. Interested students may come separately for further training. A number of medical students from other Medical Schools elect one month of family planning instruction. In the past three years, we have had a number of first year medical students participating in our clinic. Usually our medical students do not receive clinical experience until the third year. We pay special attention to these fledgeling clinicians. Two of these first year students spent two years with us attending clinic in free time from their other

commitments and one complete summer. They received certificates in Family Planning just as we give to our other trainees and were awarded Honorary Midwife Degrees. Now at the end of their third year in medical school, they have declared their intention of seeking a residency in obstetrics and gynecology after completion of their fourth year.

Nursing students from both hospitals and from other nearby institutions observe our operation. We try to serve as role-models for these aspiring nurses.

Countless professional visitors from home and abroad observe in the clinic and pick our brains on motivation and training techniques. The standard question is, "How fast can I train people in Family Planning?" My standard answer is, "What do you expect them to do after you have trained them?"

From time to time, one of our staff accepts assignment overseas for three to four months to set up a training program. Once organized and trained, the nucleus group of midwives is expected to continue the program of training others. Thus far we have begun programs in Afghanistan, Ghana, and Thailand. Plans are under way for others.

In the U.S. we are often called upon to participate as lecturers and participants in Seminars and workshops in family planning.

I have attempted to describe the enormous activity of the nurse-midwifery and physician staff in the Downstate and Kings County Medical Centers dedicated to the provision of comprehensive service in Maternal and Child Health.

An important part of this care is provided by the Post Partum

and Family Planning Clinic serving both hospitals.

It is vital that such a training and service center continue to grow and serve our local community, our American community, and our World community.

As I conclude this testimony, may I offer my gratitude and that of our staff for the privilege of being here today.

**State
University
of
New York**

**Downstate
Medical
Center**



**Nurse-
Midwifery
Training
Program
in
Family
Planning**



A branch of the State University of New York, Downstate Medical Center, located in Brooklyn, New York, is one of the largest health research and teaching complexes in the United States. It encompasses four professional schools—the College of Medicine, the School of Graduate Studies, the College of Nursing, and the College of Health Related Professions—and the 350-bed State University Hospital. It provides the clinical staff for Kings County Hospital Center, a 2,000-bed municipal hospital, and it is affiliated with nine other hospitals in the community.

Downstate's nurse-midwifery training program in family planning is administered by the College of Health Related Professions. Instruction is provided by the Department of Obstetrics and Gynecology of the College of Medicine. Financed by a grant from the Agency for International Development, the program has been operating regularly since 1966, and has over 200 graduates currently providing family planning services around

the world. With the backing of their governments and universities, some of these graduates have established similar training programs in family planning for nurse-midwives in Ghana, Senegal, and Thailand.

Program Description and Course Content

The goals of the program are threefold:

1. To train midwives and physician-midwife teams for the management of family planning clinics, including the motivation of patients, the provision of all types of contraceptive services, the diagnosis and management of associated minor gynecological and psychological problems, and the appropriate referral of persons desiring sterilization and persons with problems of infertility.
2. To operate such multilingual family-planning clinic activities as are necessary to assure adequate clinical experiences for



the training of nurse-midwives and physician-midwife teams in all types of contraceptive services and problems.

3. To provide training, direction, and consultation for nurse-midwives and physician-midwife teams in the planning and establishment of service projects and training programs in family planning.

Didactic instruction is provided in the following areas:

- Reproductive anatomy and physiology, male and female
- Breast and pelvic examinations
- Overview and history of contraception
- Endocrinology and chemistry of "the pill"
- Intrauterine devices: techniques of insertion and removal
- The vaginal diaphragm
- Cervical, vaginal, and pelvic pathology related to contraception
- Psychological problems in the use of contraception

Abortion

Problems of infertility

Pediatrics in relation to family planning

Organization and administration of family planning clinics

Demography

Downstate trainees receive their clinical experience in the Medical Center's family planning clinics, located in the State University Hospital and in the Kings County Hospital Center. Staffed by nurse-midwives under the supervision of physicians, the clinics provide services for more than 400 patients per week. The patients are medically indigent persons who live within those areas of Brooklyn served by the Kings County Hospital Center.

This three-month intensive training program is offered three times each year to a limited number of trainees. Information on the precise dates is available upon inquiry. Special arrangements can be made for several applicants from a single country.



At the end of the course, trainees should be capable of providing family planning services with minimum medical supervision.

A certificate is awarded upon successful completion of the course.

Admission Requirements

The program is open to nurse-midwives, and to professionals certified as midwives by their governments, who are citizens of a country other than the United States. Applicants must be proficient in English, Spanish, or French. They must be affiliated with a health or medical institution in their home country which will permit them to apply the training provided in the program. Preference is given to individuals who will be able to train others.

Requests for sponsorship in the program should be made through the Agency for International Development in the home country of the applicant. A limited number of

applicants who are not sponsored by AID are admitted to the program by direct application.

No tuition is charged for the course. Trainees will be allocated living quarters in apartments near the Medical Center. Lodging fees are arranged through individual scholarships. AID participants receive an allowance per month for food and personal expenses. Travel to and from the participant's home country is provided by AID or other sponsors. Applicants who do not receive travel funding from their own organizations or AID may request such funding from this program.

Applications and Inquiries

These should be addressed to:

Mrs. E. Pendleton
Department of Obstetrics and Gynecology
Downstate Medical Center — Box 24
450 Clarkson Avenue
Brooklyn, New York 11203

What Is A Nurse-Midwife?



N. Y. Times

THE AMERICAN COLLEGE OF NURSE-MIDWIVES

The professional organization for nurse-midwives in the United States dedicated to " . . . the improvement of services for mothers and babies, in cooperation with other allied groups . . . "

50 East 92nd Street, New York, N. Y. 10028

WHAT IS A NURSE-MIDWIFE?

The nurse-midwife is a Registered Nurse who by virtue of added knowledge and skill gained through an organized program of study and clinical experience recognized by the American College of Nurse-Midwives, has extended the limits of her practice into the area of management of care of mothers and babies throughout the maternity cycle so long as progress meets criteria accepted as normal.

HOW DOES SHE FUNCTION?

In association with the obstetrician to whom she is responsible, the nurse-midwife provides care as long as progress is normal. She cares for the mother during pregnancy and stays with her during labor providing continuous physical and emotional support. She evaluates progress and manages the labor and delivery, always watchful for signs requiring medical attention. She evaluates and provides immediate care for the newborn. She helps the mother to care for herself and for her infant; to adjust the home situation to the new child; and to lay a healthful foundation for future pregnancies. The nurse-midwife is prepared to teach, interpret and provide support as an integral part of her service.

In the U.S.A. a nurse-midwife always functions within the framework of a medically directed health service; *she is not an independent practitioner.*

ARE NURSE-MIDWIVES LICENSED TO PRACTICE?

The license to practice nurse-midwifery is determined by the legal jurisdiction in which the nurse-midwife is employed. Information may be obtained from local or state authorities responsible for professional licensure.

HOW DO YOU BECOME A CERTIFIED NURSE-MIDWIFE?

Nurse-Midwifery education is currently offered on a post R. N. and a Master's degree level. The post R. N. program provides a curriculum of theory and clinical experience in nurse-midwifery. The degree program offers preparation in nurse-midwifery in conjunction with a curriculum leading to a Master's degree.

If you are a Registered Nurse licensed to practice in one of the United States, apply to the program of your choice. Upon graduation you are eligible to take the American College of Nurse-Midwives national examination for certification.

If you have graduated from a Nurse-Midwifery program outside the United States and are a Registered Nurse licensed to practice in one of the United States, apply to the refresher program of your choice. Upon completion of the refresher program you are eligible to take the ACNM national examination for certification.

When a Nurse-Midwife is certified by the American College of Nurse-Midwives, she is entitled to use the initials C.N.M. after her name.

WHERE IS NURSE-MIDWIFERY TAUGHT?

Institutions currently offering basic education in nurse-midwifery, internship programs, or refresher programs are as follows:

State University of New York Nurse-Midwifery Program College of Health Related Professions Box 1216 Brooklyn, New York 11203	CB, R, I
Frontier School of Midwifery and Family Nursing Wendover Leslie County, Kentucky 41775	CB
Columbia University Graduate Program in Maternity Nursing and Nurse-Midwifery Dept. of Nursing, Faculty of Medicine Columbia-Presbyterian Medical Center 622 West 168th Street New York, New York 10032	MB

- The Johns Hopkins University **MB**
 School of Hygiene & Public Health
 Nurse-Midwifery Program
 615 North Wolfe Street
 Baltimore, Maryland 21205
- University of Utah **MB, R**
 College of Nursing
 Graduate Major in Maternal and Newborn
 Nursing and Nurse-Midwifery
 25 South Medical Drive
 Salt Lake City, Utah 84112
- Yale University School of Nursing **MB**
 Graduate Program in Maternal and Newborn
 Nursing and Nurse-Midwifery
 38 South Street
 New Haven, Connecticut 06510
- University of Mississippi **MB, CB, R**
 Nurse-Midwifery Program
 2500 North State Street
 Jackson, Mississippi 39216
- Maternal Health Service **R, I**
 The Community Hospital of Springfield
 and Clark County
 2615 East High Street
 Springfield, Ohio 45501
- Grady Memorial Hospital **R, I**
 Nurse-Midwifery Service
 80 Butler Street, S. E.
 Atlanta, Georgia 30303
- *The University of Illinois at the **MB**
 Medical Center
 College of Nursing - Dept. of
 Maternal-Child Nursing
 Nurse-Midwifery Program
 P. O. Box 6996
 Chicago, Illinois 60680
- *Loma Linda University **MB, CB**
 School of Nursing
 Nurse-Midwifery Program
 Loma Linda, California 92354
- Los Angeles County - University of **R, I**
 Southern California Medical Center
 Women's Hospital, Nurse-Midwifery Service
 1240 North Mission
 Los Angeles, California 90033
 (In collaboration with Loma Linda University)
- Booth Maternity Center **R, I**
 6051 Overbrook Avenue
 Philadelphia, Pennsylvania 19131
 in affiliation with
 Maternity Center Association
 48 E. 92nd Street, New York, New York 10028
- St. Louis University **R**
 Nurse-Midwifery Program
 1401 South Grand Boulevard
 St. Louis, Missouri 63104
- Beth Israel Medical Center **R**
 Nurse-Midwifery Service
 5 Dazian Building
 10 Nathan D. Perlman Place
 New York, New York 10003
- *United States Air Force **CB**
 Nurse-Midwifery Program
 Malcolm Grow USAF Medical Center
 Andrews Air Force Base, Maryland 20331

CB — Certificate Basic Nurse-Midwifery Program
 MB — Master's Degree Basic Nurse-Midwifery Program
 R — Refresher Program
 I — Internship Program

*Approval Pending

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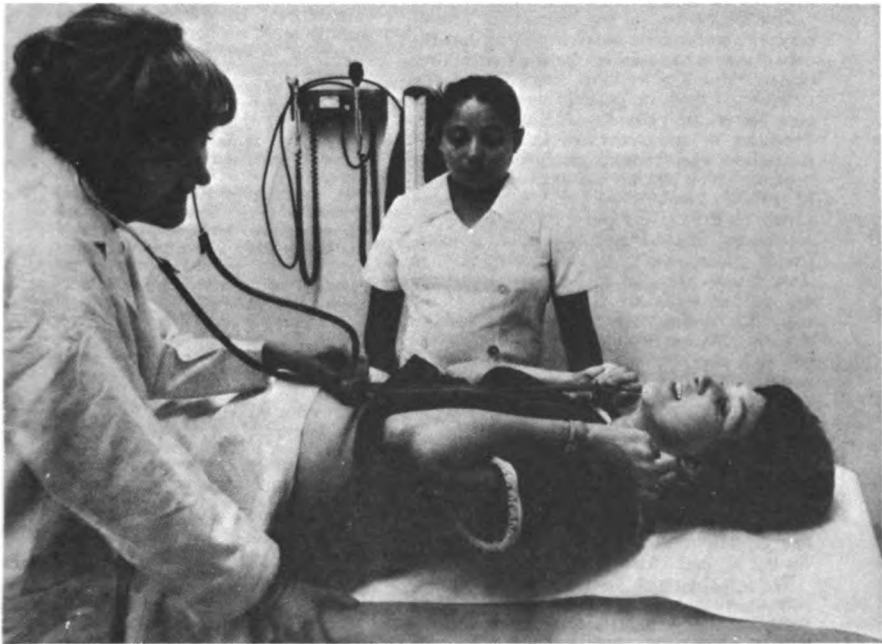
THE MIDWIFE RETURNS— MODERN STYLE

*Here's why an increasing number
of mothers-to-be are relying
on certified nurse-midwives for
full care—from first visit
right through delivery*

by Dorothea M. Lang

*Director, Nurse-Midwifery Service Program
New York City Department of Health*

PHOTOGRAPH BY JAMES EDENBAUGH
N.Y.C. DEPT. OF HEALTH



Cheryl and I have a baby boy," my brother said exultantly when he called to announce the birth of his third child. But he wasn't so exultant as he went on to describe the circumstances of his wife's delivery. Cheryl's obstetrician, it seems, almost didn't make it to the hospital in time for the birth. In fact, he arrived too late to perform an episiotomy, with painful and potentially troublesome consequences.

Ironically enough, Cheryl had selected this particular obstetrician because of his warm and human concern for each of his patients. She liked his ability to put her at ease by answering her many questions, and he was well acquainted with her past medical history—even though he had not arrived in time for her previous delivery. That time a resident physician-in-training had been called in at the last minute to take charge.

Cheryl was inclined to be sympathetic with her doctor, however, for she was a registered nurse herself, and well aware of the impossibly busy schedules of most obstetricians. While Cheryl was in labor, she knew her doctor's office was full of expectant mothers awaiting check-ups by him.

This experience in my immediate family serves to underscore what American health-care planners have known for some time, that obstetricians are in short supply. And the situation is likely to get still worse before it gets better. In 1970, Dr. J. Robert Willson, President of the American College of Obstetricians and Gynecologists, wrote in the organization's official newsletter: "There is little hope of solving the problem in the near future by graduating more physicians or by attempting to increase the number of obstetrician-gynecologists. At the present time at least fifteen per cent of residency positions are unfilled and more than one-third of the residents on duty are graduates of foreign schools." Within ten years, four out of ten babies in the U. S. will be delivered without a physician of any kind in attendance, according to a prediction by Dr. Louis Hellman, the internationally known American obstetrician who is currently Special Assistant to the President on Population Problems.

In light of this gloomy prospect, what can be done to head off a national crisis in prenatal and maternity care? Fortunately, there has been a most promising development—the use of certified nurse-midwives.

Though the term "midwife" is apt to conjure up visions of stooped grannies with no formal training, today's certified nurse-midwife is a medically competent professional, up-to-date in every way. She has been specially trained to provide complete maternity care from early pregnancy right through delivery—so long as the patient's progress remains normal. However, she is never an independent practitioner. Should any complication arise, she immediately refers the case to the obstetrician to whom she is responsible and he then takes over the case.

To become a certified nurse-midwife a woman must be a registered nurse, preferably with some on-the-job experience. She must complete an additional one- to two-year educational program recognized by the American College of Nurse-Midwives, and she must then pass a National Certification Examination.

In January 1971 the certified nurse-midwife was endorsed as a key non-physician member of the modern obstetrical team in the "Joint Statement on Maternity Care," issued by the American College of Obstetricians and Gynecologists and their Nurses Association along with the American College of Nurse-Midwives. It was stated that "qualified nurse-midwives may assume responsibility for the complete care and management of uncomplicated maternity patients." (Nurse-midwives, of course, enable overworked physicians to devote more time to patients with complications.)

Training in nurse-midwifery is highly practical. At Brooklyn's Downstate Medical Center, for example, prospective nurse-midwives frequently serve an optional six-month internship in the maternity wards in addition to their regular midwifery education program. During this time each midwifery student may perform as many as 120 deliveries, approximately the same number that the average physician performs during his training.

In addition to providing personal maternity care, nurse-midwives are trained to give comprehensive family health education and counseling about such matters as birth control, the changes and possible discomforts of pregnancy, and various aspects of infant care. Women often feel free to discuss personal problems—particularly those related to sex—with a nurse-midwife than with an obstetrician.

Lorraine Acosta, whose first baby was delivered by a midwife this year, couldn't be more enthusiastic about her experience. In her seventh month of pregnancy Lorraine was assigned to Sandra Alexander, a student nurse-midwife in Yale University's master's degree training program who was getting her clinical experience at New York's Beth Israel Hospital. From then on, Lorraine's case was handled entirely by Sandra, although her supervising nurse-midwife was in attendance for each of the prenatal exams and the delivery itself. During this period Lorraine and Sandra developed a close relationship.

According to Lorraine, this personal rapport made her labor much more bearable: "Sandra was there to explain what was happening during the whole six hours of labor. She gave me the confidence that I was going to come through it all right."

Several weeks after the birth,

Sandra visited Lorraine's home to see how mother and child were getting along and to offer advice on infant care. Lorraine was particularly enthusiastic about the family planning information she received. She commented, "Sandra explained various contraceptive methods and helped me make an informed decision."

Lorraine has become an ardent promoter of nurse-midwives: "I tell every pregnant woman I know to have a midwife."

Sandra Alexander, who had worked in general nursing for a year before she began training as a midwife, is equally enthusiastic. One of the things that most attracted her to the field was the possibility of developing a continuing relationship with her patients. From her point of view, the birth of Lorraine Acosta's first child was a "remarkable experience." She explains, "The kind of personal support—emotional as well as medical—that I was able to give Lorraine is the ideal that nurse-midwives strive for."

The first school of nurse-midwifery in this country was founded in 1931 in New York City by the Maternity Center Association. The midwifery training offered at this institution was patterned after the educational system of England, where midwifery was much more common. Over the years, however, training has evolved to meet the special needs of the United States. Currently nine institutions—from New York to Utah to Puerto Rico—offer basic midwifery training, and their number is expected to increase dramatically within the next few years. The American College of Nurse-Midwives is the professional organization that sets the standards for quality midwifery care and provides guidelines and accreditation for educational programs. This month the U. S. group has the honor of hosting the International Congress of Midwives in Washington, D.C.; it will be the first time the Congress has been held in North America.

At present there are some 1,200 practicing nurse-midwives in the United States, 600 of whom are certified by the College of Nurse-Midwives. Because of a recent change in certification procedures, this number is likely to increase significantly within the next few months. In addition, there are more than 1,200 foreign-trained midwives now residing in the U. S. Many of these women are expected to gain certification here by taking refresher courses.

Health care planners are particularly interested in the possibility of a wider use of midwives to provide maternity care, because such a trend could substantially lower the cost of health care for women. The experience of the New York City Health Department indicates that a certified nurse-midwife can care for approximately three-fourths as many prenatal patients in a morning as the average obstetrician; her per-hour salary is considerably less than that of the obstetrician. Moreover, the nurse-midwife frequently provides

services over and above the usual range of obstetrical care—for example, individual counseling and general health education.

Perhaps because they represent a relatively new specialty—or possibly because, as women, they are sensitively attuned to the likely discomforts of labor and delivery—nurse-midwives have been particularly successful in adapting rigid hospital procedures to the needs of the pregnant woman and her husband.

In other countries, midwives frequently deliver babies in the familiar atmosphere of the patient's home. In this country, certified nurse-midwives perform deliveries only in a hospital setting. However, they believe that some family member or close friend should always be allowed to accompany the mother-to-be into the labor room and occasionally into the delivery room as well. Of course, many hospitals have ruled against this practice. But nurse-midwives in two New York City hospitals have succeeded in changing institutional regulations to enable fathers-to-be and even grandmothers or close women friends let into the labor room. Mothers and fathers have been unanimously enthusiastic about this new policy.

Nurse-midwives have also been instrumental in introducing a change in the traditional birth position. For years American women have given birth flat on their backs. Yet many persons in and out of medicine maintain that this position was chosen for the doctor's convenience rather than for the laboring woman's comfort or the baby's well-being. Physicians and nurses have repeatedly noted that many women seem to have a natural desire to sit up in bed in a tailor-like position during active labor. This preference appears to be an instinctive reaction of the body to enhance the natural forces in action during the birth process. If the mother's back is elevated from the bed and flexed forward, the uterine and abdominal muscles can more naturally direct the fetus through the normal curvatures of the mother's pelvic canal, thus apparently shortening her labor.

One certified nurse-midwife has even designed a Styrofoam wedge to comfortably elevate the laboring woman's back. Another midwife uses a specially designed adjustable wooden back-rest, padded for softness. Other nurse-midwives simply elevate the head portion of the labor beds and delivery tables or use several pillows to provide the desired elevation. Although no comprehensive study of the effectiveness of various labor and delivery positions has been made so far, most patients express a preference for the elevated position.

The new procedures being introduced by certified nurse-midwives are almost as numerous as the practitioners themselves. In one hospital, for example, midwives set up an early-labor lounge, where patients can relax, and have tea with their

(Continued)

husbands rather than be needlessly confined to bed. Nurse-midwives in several other hospitals have persuaded administrative officials to allow the infants of minimally-medicated mothers to breastfeed immediately following birth, while still on the delivery table. In addition to the practice's being a gratifying emotional experience for the new mother, medical textbooks confirm the fact that the infant's sucking stimulates uterine contractions in the mother, often hastening the expulsion of the placenta. A nurse-midwife in yet another hospital was distressed because patients were always moved during the most difficult last phase of labor from the labor room to the delivery room. This transfer often requires active climbing or sliding over from bed to stretcher to delivery table at a time when the patient is in maximum discomfort. With the permission of the obstetrician, the midwife in question allowed women whose labor was normal to stay in the labor room for birth itself.

These and other advances made by

certified nurse-midwives thus far give hope for significant improvement in the human dimension of maternity care in this country. How widely they are adapted in the future will depend primarily on whether Americans are willing to re-evaluate their traditional ideas about good medical care. At present the vast majority of middle-class women still feel that their babies must be delivered by a physician, preferably an obstetrician. Yet experience in many other nations does not support this belief. Approximately 80 per cent of the world's babies are delivered by nurse-midwives. And this is the case not simply in underdeveloped countries, where midwifery is naturally prevalent. In most of Western Europe—in several nations with lower infant and maternal death rates than our own—care by midwife is the norm.

Clearly, the midwife should not be looked upon as second-best to a doctor. But, as the 1970s progress, more and more women will be discovering how warm and competent the new-style midwives can be. ■

STATE UNIVERSITY
OF NEW YORK
DOWNSTATE MEDICAL CENTER

• DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

June 1, 1973

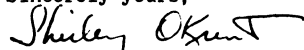
Senator Alan Cranston
Chairman, Special Subcommittee on Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator:

I was delighted to receive your letter of May 15, 1973 with the enclosed questions pertaining to my written testimony which I unhappily did not get the opportunity to read at the hearing. Missing that hearing was a most frustrating and disappointing experience for me. After reading your letter, I know that I would have enjoyed meeting you and speaking with you.

I have enclosed ~~some~~ answers to your questions and hope that I interpreted your inquiries correctly. Please don't hesitate to call on me again.

Sincerely yours,



Shirley Okrent, R.N. C.N.M.
Coordinator of Nurse Midwifery Activities
in Family Planning at Kings County Hospital Center
and Downstate Medical Centers

Questions for Mrs. Okrent:

1. As Director of a major urban program offering family planning services in an organized setting, what do you think the effect of the Administration's proposal to limit expansion of support of family planning services to Medicaid and title IV-A programs will be in your community?
2. Does your center receive a substantial portion of its income from Medicaid reimbursements?
3. Could you tell me what the costs on the average are of training nurse midwives and the duration of the training?
4. What is the source of funding for these programs?
5. Have you determined the effect of utilizing nurse midwives on the program's capacity to treat additional patients?

Answers from Mrs. Okrent to Senator Cranston:

1. Let me explain that I am not the director of this program. Dr. Schuyler G. Kohl is the director. I am in charge of the clinical activity of the nurse-midwives, give direct service to patients and participate in the instruction of students in the Post Partum and Family Planning clinics.

However, I can say that a proposal to limit the expansion of support of Family Planning services to Medicaid and Title IV A programs will increase the number of patients in city or county hospitals like Kings County Hospital, since the people will not be able to afford services in voluntary hospitals to which they now go. Also, a certain number of patients might not even transfer over to public hospitals, but might discontinue contraception if they are turned away from the clinics they now attend with the Medicaid benefits.

2. I do not know what portion of our center's income is derived from Medicaid reimbursements. This information could be obtained from the Health and Hospitals Corp.

3. Nurse-midwifery education in this country is based on Nursing education; that is, one must first be registered in a state to practice professional nursing before applying for midwifery training.

In a certificate program such as ours, we could prepare a registered professional nurse as a nurse-midwife in a period of 6-8 months depending upon the level of preparation she comes with. Many of the applicants already have a M.S. and B.S. degree in Nursing, others have many years of experience in obstetrics.

Because of the close function of our education and service programs and other clinic functions with the Dept. of Obs-Gyn it is difficult to arrive at a cost figure.

Family Planning is included in all of our Nurse-Midwifery programs.

4. The source of funding for these programs are:

- a) Grants from the National Institutes of Health
- b) " " the Commonwealth Fund
- c) " " Health Services Mental Health Admin.
- d) " " U.S. A.I.D.

These grants also pay for some of the Faculty's salaries and student support.

5. The effect of utilizing nurse midwives in our program has made it possible to extend family planning services to many more patients than would be possible with physicians. It would hardly be possible to obtain 6-8 physicians that would have the time to devote 21 hours a week to the clinic services even if we didn't have a training program.

NEW YORK STATE RIGHT TO LIFE COMMITTEE

Founded 1967

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May 10, 1973

TO: MEMBERS OF THE WELFARE AND LABOR COMMITTEE

FROM: JOHN MIDDLETON, Ph. D., Marriage and Family
Life Educator and Counselor, Vice-Chairman
New York State Right to Life

RE: Cranston Family Planning Bill

Distinguished Members of the Committee, Mr. Cranston:

On behalf of New York State Right to Life,
as a professional representative of family life education,
family counseling, family sociology, and as a sex educator,
it is my privilege to share a few moments condensing
several years of study, practice and research.

The Bill in question represents nearly one
billion dollars (\$973 million) during the next three
fiscal years and should, therefore, be based on the very
best available evidence that it will, in fact, aid the
country in very large ways and not, in fact, be damaging
to this great nation. It appears to be an implementation
of a recent Commission Report which "found" much contro-
versial data and was rejected by the President who
authorized it. Let us not be deluded, this bill sets up
machinery for a grossly expensive control and research
Agency which could act for private family life as the

Directors:
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2.

Occupational Safety and Health Act does for private business. It is a matter of record in Congress, from several "expert" witnesses that the tag "voluntary" is the foot in the deer tactic and that any population control in the context of this bill must be clearly regulated to achieve effectiveness. Any statements about voluntarism and no abortion programs could be easily amended after passage. It is important to see that Section 1000, Subdivision (1) of unwanted and health threatening pregnancies, which in today's practices means abortions as back up measures, may well be literally contradicted by the simple statement in Section 1008 succinctly expressing the opposite. Tight rope walking is indicated and some court may well say that abortion is not a method of family planning and render the safeguard against abortion meaningless. The majority of Americans want no part of abortion. The "majority" here is attested to by the survey published by Better Homes and Gardens, October 1972, where 350,000 people showed that 59% do not want abortion considered in family planning. The States of North Dakota and Michigan in an overwhelming public vote, November 7, 1972, rejected abortion and those two States probably represent the nation. Surveys by Institute of Social Research, University of Michigan, published in the Evening Star and Daily News, Washington, D. C., April 17, 1973, show further rejection of abortion.

Aside from opinions of the majority of our population, the evidence amassed by the Foundation For Education and Research in Child Bearing, London, England, shows abortion to be a major

3.

risk to children born subsequently to a mother's prior abortion. The evidence is overwhelming and is a matter for public health, not a group of quasi health bodies. A copy of the report is part of the prepared report for your perusal. If the Bill intends to reject abortion, it should so state much more explicitly and convincingly than it does now.

Now for the contraception and family planning provisions of the Bill. It is assumed that the "Dooms Day" tactics of some population alarmists have come and gone in this august body and that the U. S. Department of Agriculture and U. S. Census Bureau reports of the reasonable projections about population have also been tempered by the fires of controversy. In reference to contraception, there are governmental programs both national and international, which promote and disseminate contraceptive pills, intra-uterine devices, abortifacients, and other methods. These procedures and practices, costing millions, are based on the assumption that the practices are for the benefit of society. So well accepted are these practices that tax exempt and tax supported agencies are supplying all the materials and even the transportation (welfare recipients) to assure that all people are given the opportunity to benefit. Tax exempt and tax supported agencies and organizations are providing educational programs and encouraging contraceptive pills to children and adults, to all children from puberty, whether or not parents approve or even against parents' wishes. It is an interesting paradox to note that persons (females) taking the pill are reported to be 20% more

4.

susceptible to venereal disease than those not taking the pill, and encouraging young people to not only carry but to take the pills indirectly encourages sexual activity. The current epidemic of venereal disease (USPHS) cannot be dissociated from the impact of distribution of the pills and educational programs. Such a fact as possible association between the pill and venereal diseases is, of course, aside from any other reported complications or side effects of the pills. It has even been reported in various sources that when contraceptive pills are freely distributed in a society, there have been noted increases in venereal disease, abortions and illegitimacy. From a public health perspective, it would appear that freely distributing the pill to teenagers is contraindicated to the well-being of that society. It seems that most planners of U. S. policy and domestic programs have a Swedish model in mind, particularly in terms of its "contraceptive mentality". Sweden's climbing social problems include suicide, juvenile delinquency, drug abuse, homosexuality and the highest per capita venereal disease rate in Europe, with the peak age for crime down from 21 years in 1920 to 14 years in 1967. Frederick Fleisher, The New Sweden, (New York, David McKay Co. 1967), pp 215-218.

Sexual morality and all the mediated morality we hear about cannot really be separated from the focus of the Bill in question. Sexual morality is an often mentioned subject in the media. Most popular literature on the subject comments on how sexually active young people are today. Young people, particularly high school and college age, are said to be

5.

regularly involved in sex. Objective evidence does not support conclusions that most teenagers are sexually active. Evidence from a study in 1971 at Plattsburgh State College shows no real difference in the incidence of premarital sexual experiences, chastity - between studies on comparable groups begun in 1922 and continuing through the years. At the time of the most recent study there was no evidence that the sexual activity of the college students today is more than in previous years. There are, however, the objective findings that even the college age young people are caught up in believing that most of their peers are engaged in or have had premarital sex. The empirical evidence says simply "that everybody is not doing it but everybody is talking about everybody doing it."

Sex educators today most often push or advise an approach made popular by SEICUS which advocates a situational morality to replace "old, worn out" religious convictions. Knowingly or unknowingly the advocates of the so-called new morality are educating toward a freer sexual behavior. This factor, when coupled with the advocates of contraception for all teenagers (active or not) and the assurance of back-up abortion for any "contraceptive failures" contribute very heavily to a breakdown in parental authority, and a breakdown in the self-respect of individuals. Those who advocate freer sex with anyone as long as it is rationalized not to hurt others seem to prey on the most logical victim in the young adolescent whose sexual energies and curiosities are awakening. The young people make logical and, as a group,

6.

not greatly resistive followers of the adults who cater to their sexual whims as contrasted to the adults who advocates sexual restraint, moral vigor, and followers of "square" values.

In a text book on family life by Robert Blood the following problems are found described to be related to couples who practices premarital sex.

- a) blunting of relationships (less intense emotional response)
- b) failure to continue maturing in a psychosexual or psychosocial manner.
- c) dehumanization of the sex act
- d) higher divorce rate
- e) higher number of extra marital affairs
- f) less happiness with self

In spite of the consistent research findings by family life sociologists, not moralists, that chastity before marriage is associated with more marital happiness, it seems that educators in both private and public schools are promoting an atmosphere of premarital sex. One is left puzzling why, for what purpose?

The Bill under consideration apparently is based on the premise that people are going to become more sexually active, that a means of controlling conceptions is necessary and every phase must be educated and researched, controlled and further educated.

May I call your attention to the fact that the best means known to destroy family life have been practiced by the

7.

Communists in Russia and China and were also borrowed by the Nazi. These means include several of the present practices promoted by the benefactors of present appropriations under the massive efforts to get contraception and all its sequelae into the mainstream of society.

It is my opinion that the practices and procedures inherent in this Bill will greatly aid efforts to destroy the family and therefore our society and whatever benefits may be in the Bill are more than offset by the multi-headed monster it creates.

509 Westview Drive, 3-A
 Missoula, Montana 59801
 7 May 1973

Chairman, Human Resources Subcommittee
 Senate Labor and Public Welfare Committee
 Washington, D.C. 20510

Dear Mr. Chairman:

I am most appreciative of the opportunity to submit a statement in support of the proposed "Family Planning Services and Population Research Amendments of 1973," as suggested by Senator Metcalf.

My name is Frances Dummer Logan. I am a grandmother, a widow residing in Missoula. Before my marriage I was a psychiatric social worker. My last employment was as Director of the Department of Educational Counsel in the public schools of Winnetka, Illinois.

For the past two and a half years I have been a volunteer at Planned Parenthood of Missoula, Montana, Inc., Chairman of its Information and Education Committee. For the past year, Chairman of the Information and Education Committee of the Midwest Region of Planned Parenthood Federation of America. However, this statement is my own and does not purport to represent any organization.

I support this proposed bill enthusiastically. Perhaps the best way to indicate its merit is by comparing it with the Administration's bill, H.R. 6588.

The Family Planning Services Amendments would continue Family Planning under Title X as a viable, separate entity under an Assistant Secretary^{for} Family Planning and Population Science. H.R. 6588 would lump family planning with other health services under Title III B. It does not even mention family planning. These proposed Amendments would continue support for family planning by authorizing specific amounts for specific years. Under H.R. 6588 the Secretary could continue support for family planning under block grants, could lower the amount of the grants, or could discontinue support altogether. Family Planning would probably be

unable to compete for funds with other health services such as day care centers or neighborhood health services.

The Need

Montana is a low income state

Of the approximately 6.6 million low income women in the age group at risk, only 3.2 million women have been reached. Nor would the task be accomplished were the entire number reached, for many thousands leave and other move into the child-bearing years each year, making the task, like education, a continuing one.

The need in Montana is greater, in proportion to population, than the need in the nation at large, for per capita income is only 84 per cent of the average per capita income for the country.

Per capita income, U.S.	\$4,138 *
" " " Montana	3,479

*Figures for 1971. Department of Commerce data for 1972 not available.

This would mean that the proportion of women in need of and eligible for free contraceptive service would be larger than in most states.

Illegitimacy is increasing

Illegitimacy has increased more than five fold in Montana in less than 20 years.

<u>Date</u>	<u>Number</u>	<u>Per 1,000 Live Births</u>
1953	291	17.5
1970	1,048	95.3 *
1972	1,259	110.2 #

* Montana Vital Statistics
Provisional

Other reasons showing how sorely continuation and expansion of family planning services are needed in Montana have been stated better than I can describe them by Dr. Kit G. Johnson, Missoula City-County Health Officer, in testimony before the Public Safety

Health and Welfare Committee of the Montana House of Representatives, and in a letter written to state government officials following failure of passage of a bill to expand family planning services. They are appended with Dr. Johnson's permission.

Comments

May I now comment, section by section, on certain provisions of the proposed Amendments which appear to me especially good, and others which might be modified to strengthen the bill further?

Section 1000: I am glad to see in Subsection (1) new wording, not included in the 1970 Act, "particularly persons from low-income families and others at high risk of unwanted or health-threatening pregnancy." I have already mentioned certain such persons under The Need. Dr. Johnson cites further persuasive evidence for the value of such wording.

(5) "assistance to develop and make readily available information (including educational materials)...."

While some very vocal groups insist any move by schools to give sex education is an invasion of the rights of the parents, the rights of children should also be considered. These days, teenagers, even children are constantly bombarded by sex in movies, TV, magazines, news media and advertising of everything from cigarettes to cars, from toothbrushes to deodorants, all profit motivated. They need and have a right to a different kind of sex education, "responsible family living", "education for marriage and parenthood," call it what you will, motivated only by the desire to help young people grow into mature, responsible adulthood.

Many parents, for a variety of reasons, are not able to communicate with their children about sex except to lay down strict, arbitrary standards of morality, standards which young people see being abandoned by larger and larger numbers of adults. They want facts. They want grownups to "level with them", to help them learn the consequences of various kinds of behavior and make their own de-

cisions. They respond well to such teaching in schools which do provide it, (See Attachment 3) and are inordinately grateful to the rare teachers and counselors who dare to talk about such things in schools which do not.

I suggest that some entity be given the responsibility, perhaps in conjunction with the appropriate division of the Bureau of Education, for; (1) collecting and disseminating information about successful programs already being carried on in schools, churches and other community groups; (2) creating materials suitable for incorporation into usual school subject matter such as biology, social science, health, domestic science, suitable for use at several different grade levels, commensurate with the maturity of children; (3) separate courses on population and related subjects, responsible family living.

School boards, zealous to guard local autonomy, might be more ready to accept such innovative material if there were a choice, rather than one "take it or leave it" course.

(7) Assistance in providing trained manpower. We have seen evidence of lack of trained staff in new family planning programs. However, setting up private profit instructional groups, de novo for this purpose may be called into question. In Region VIII personnel of such a new group received their initial training in Montana. Later some came back and tried to impose first level workshops on some of the very people who had trained them in the first place. I have been told the same thing happened in Region V. As I understand it, these groups are paid in proportion to the number of workshops held (or persons attending workshops ?)

In contrast, in the South-East Region, the training grant was given to Planned Parenthood of Baltimore, one of the oldest family planning programs in the country, a private but non-profit corporation. I visited their training center last year and was much impressed.

Section 1002 (b) "but only to the extent that the Secretary determines that the applicant has been able to obtain such pay-

ments on a timely and continuing basis." An excellent provision. Delay in receiving payment covering operation, especially salaries, works a hardship on local programs. I have seen staff who had a hard time making ends meet when their checks were more than a month overdue.

Section 1001 (5) (c) (page 7) Prevention of delay by review by the Office of Management and Budget. Excellent! Would it be possible to include a provision preventing impoundment of funds appropriated by Congress under this Act? This is important not only for Family Planning Services but for all domestic programs authorized by Congress but curtailed, thwarted, even killed, by the Executive branch.

In this connection, would it be possible to prevent the Secretary, or a subordinate, from promulgating such restrictive regulations that carrying out the intent of the law is virtually prevented? I refer to proposed regulations issued Feb. 16, 1973, restricting eligibility, requiring case by case income determination, a written social service plan to be reviewed every six months as a condition of continued assistance, etc. The provision that only those likely to need assistance within 6 months is scarcely in accord with the biological facts of life for family planning patients.

Section 1002 (c), also Sec. 1003 (c), Sec. 1004 (c) and Sec. 1005 (c). As a layman, unused to the formalities of bill drafting, it is difficult to understand why a bill proposed to be introduced in 1973 makes provision for funding in 1970, 1971 and 1972.

Section 1003 (a) "(including nurse midwives)": Would it be desirable to include "nurse practitioner" as well as "midwives"? The two carry different connotations, at least in the minds of the lay public. Nurse practitioners are increasingly performing duties in clinics formerly performed only by physicians. In view of the scarcity of physicians and the greater cost of their time, this would seem desirable.

Section 1006 (3), (4), and (5). Provision for "comprehensive child and maternal health care" by whatever means are available to

programs in diverse locations, is excellent, as is the provision that low-income persons to be served, (we call them "consumers") participate in decision making.

While comprehensive health planning advisory groups set up to comply with the provisions of authorizing laws may be desirable in some cases, we have observed one program which has been delayed, obstructed, almost destroyed by such a board composed largely of persons of one faith who disapprove of all but the one contraceptive method considered "licit" by their faith. Should such a situation be permitted to prevent service to persons of other faiths in the community?

Page 16, Lines 3-16. In the short time available to prepare comment I was unable to learn how the income levels as determined by the BLS "lower living standard budget" compare with guidelines presently in use. I would hope that, in view of continuing inflation, they would at the very least be no lower. Could they contain a provision for adjustment to rising costs of living? Could provision be made to prevent administrative reduction?

Section 1007, Voluntary Participation. I am delighted to see that this provision continues to be included.

Section 1009, I applaud the provision that a recipient of services shall be a member of the Advisory Council.

Section 1010, The provision that population be considered in relation to the total human environment puts the whole program in perspective. It is a most desirable addition.

Again, Mr. Chairman, may I thank you for permission to submit this statement?

Respectfully,

Frances Dummer Logan
Frances Dummer Logan

Attachments:

Kit G. Johnson, M.D., Missoula City-County Health Officer
Statement in Support of Family Planning Legislation
Letter to Montana State officials
Kansas City Times, Nov. 9, 1972
Sex Education Works in One Town

TELEPHONE 728-4510

MISSOULA CITY-COUNTY HEALTH DEPARTMENT

COUNTY COURTHOUSE ANNEX, ROOM 301

MISSOULA, MONTANA, 59801

TESTIMONY IN SUPPORT OF HOUSE BILL #302, FEBRUARY 6, 1973

There are six principal reasons, that I as a concerned citizen, physician and public health official of Montana endorses House Bill #302, to support family planning, and strongly urge you to adopt it at this Legislative session.

I. The first reason is the tragedy of unwanted pregnancies.

Initially, let me state that every unplanned pregnancy is not an unwanted pregnancy. Many of us, and many of our children are the products of unplanned pregnancies. However, as a practicing pediatrician, I become painfully aware of the tragic consequences of unplanned pregnancies, which are also unwanted pregnancies. Women of any age, bearing unwanted pregnancies, usually have four painful alternatives:

First, suicide is often contemplated, but fortunately when attempted, it is only occasionally successful.

Second, an induced abortion is one of the most frequently used solutions for the unwanted pregnancy. Presently I see about four women each month who are seeking referral to the State of Washington for an induced abortion. Some of my colleagues in the private practice of obstetrics in Missoula, tell me they are seeing a similar number. This indicates that as many as 30-40 women from Missoula, may be seeking abortions each month! Induced abortions are not a safe or physiological method of planned parenthood. The tragic fact is, that in areas where women are denied access to safe and physiological methods of contraception, they often resort to abortions. There are cities in South America where contraceptives are banned by law and where one of the leading causes of death among women in the productive age group, is induced abortions. In light of the recent Supreme Court decision regarding abortions, we must expect that, in the absence of access to contraceptive information and supplies, an increasing number of young women will seek induced abortions as their solution for an unwanted pregnancy.

Third, adoption of the unwanted child is another option for the unwanted pregnancy. However, this solution is decreasing in popularity, as young girls prefer other alternatives to being used only as reproductive animals. Moreover, there is increasing evidence that mothers suffer greater

psychological damage if they carry their pregnancy through term, and then give up a living child, than they do by obtaining an early induced abortion.

Fourth, keeping and raising an unwanted child is perhaps the most tragic solution of all. As a pediatrician, all too often, I have observed the permanent physical, mental and emotional injuries inflicted upon these children. The rate of physical child abuse alone is about twice as high for products of "unwanted pregnancies". The emotional deprivation which these children suffer and the resulting impact on them and our society cannot be measured.

II. The second principal reason that I support liberalized contraceptive legislation, is the right of a mother for planned parenthood in order to protect her health.

The medical evidence proving that planned parenthood improves the health and protects the lives of mothers, is absolutely incontestable. Our society must allow our mothers to seek the family planning methods which best suit their personal needs without interference by the State.

III. The third reason is the right of children to live in families practicing planned parenthood in order to protect their health and welfare.

Medical evidence also proves that planned parenthood improves children's health, both directly by reducing mortality and morbidity rates and by improving their growth and development; and, also, indirectly through increasing their probability of retaining a healthy living mother.

IV. My fourth reason to support an increased availability of contraceptives is as one means of containing our exploding venereal disease epidemic.

Nationally, the reported gonorrhea case rate increased 13% from 1971 to 1972. Locally, the visits to the Missoula City-County Health Department's Clinic for Venereal Diseases, increased from 71 in 1969 to 882 in 1972. While the number of cases of gonorrhea, increased from 19 in 1969 to 178 in 1972. Ten percent of our local public health expenditures are for venereal disease control and these expenditures will continue to increase until this epidemic is controlled. These are not minor diseases. They threaten the health and fertility of a whole generation. Although it is reasonable to believe that one of the factors contributing to our present venereal disease epidemic is the use of certain contraceptive methods, there is also sound evidence that making condoms readily available to youth, would decrease the spread of venereal disease. One study in World War I indicated that the gonorrheal case rate among troops was reduced from 625 cases per 1000 to 35 per 1000 by supplying the troops with condoms.

- 3 -

V. Another principal reason that I support House Bill #202, is my philosophical belief in equal rights for all of our citizens.

The present laws of Montana, do not prevent affluent, intelligent, sophisticated adults from obtaining any contraceptive devices known to man. However, minors, the unsophisticated, the poor and the uninformed are denied or deterred from obtaining even the simplest contraceptive advice and material. It is a tragic paradox that under our existing Montana laws and subsequent to the Supreme Court decision legalizing abortions, a physician cannot legally advise a minor girl regarding contraceptives without parental consent, but after she is pregnant, he can perform an abortion upon her without parental consent or knowledge.

VI. The final principal reason I support enlightened family planning, is that as a public health official, I am constantly aware that our pollution crisis is a direct result of increased consumer utilization by an exploding population. We must control ourselves, or nature will do it for us, perhaps disastrously.

Conclusion: For the public health and safety of our society, I encourage you to enact House Bill #202.



Kit G. Johnson, M.D., M.P.H.
Health Officer
Missoula City-County Health Department

TELEPHONE 728-4510

MISSOULA CITY-COUNTY HEALTH DEPARTMENT

COUNTY COURTHOUSE ANNEX, ROOM 301

MISSOULA, MONTANA, 59801

This letter was sent to:

The Governor
 Members of the State Board of Health
 Members of the State Board of Education
 Members of the Pharmacy Board
 The Superintendent of Public Instruction
 Members of the State House and Senate from
 Missoula County

It will also appear in the News Letter of the Montana
 Medical Society which goes to more than
 700 Physicians

Dear

This letter is an attempt to provide you with some hard facts relative to the consequences of the inter-action of our society's present sexual activities and our State's present official laws and policies regarding sexual education and contraceptive dissemination. This data was derived from the Missoula City-County Health Department Venereal Disease Clinic and associated Family Planning Clinic.

I. Age distribution of 759 V.D. Clinic clients during 1972:

<u>Age</u>	<u>Male</u>	<u>Female</u>	<u>Total</u>
0-14	0.5%	0.9%	1.4%
15-19	9%	24%	33%
20-24	20%	21%	42%
25-29	11%	6%	18%
30+	4%	3%	6%

II. Eighty-eight percent of these 759 people were not married.

III. Pregnancy tests were administered to 489 women during 1972. Thirty percent of these women were minor girls, 18 years old or younger. Thirty-eight percent of these minor girls were pregnant: therefore, there is a known pregnancy rate among minor girls in Missoula County of about 1.5 to 2%.

IV. One hundred and sixteen women sought abortion referrals (to Family Planning units in Washington State). Ninety-five percent of these women were unmarried. Thirty-one percent of these women were minor girls, 18 years old or younger.

Page 2

In view of this data, I recommend that the State of Montana actively promote:

1. An effective program of sexual education for adolescents and adults emphasizing:
 - a. Personal responsibility for sexual activity.
 - b. Personal and social consequences of unwanted pregnancies.
 - c. Personal and social consequences of venereal diseases.
 - d. Methods of prevention of venereal diseases.
 - e. Methods of prevention of unwanted pregnancies.
2. Laws and policies to prevent venereal disease and unwanted pregnancies by promoting the utilization of condoms and other contraceptives, especially by sexually active, young, unmarried women in whom unwanted pregnancies have the most tragic consequences.

Sincerely,

Kit G. Johnson, M.D., M.P.H.
Health Officer

KGJ/jmo

Sex Education Works in One Town

By Mary Lee

Keokuk, Iowa—Records kept by a teacher in Keokuk since 1947 show dramatically lower rates of illegitimate births and divorce among those students who took a sex education course at Keokuk High School.

Illegitimate births among girls who took the course were 10 per cent, compared with 16 per cent among girls who did not take the course.

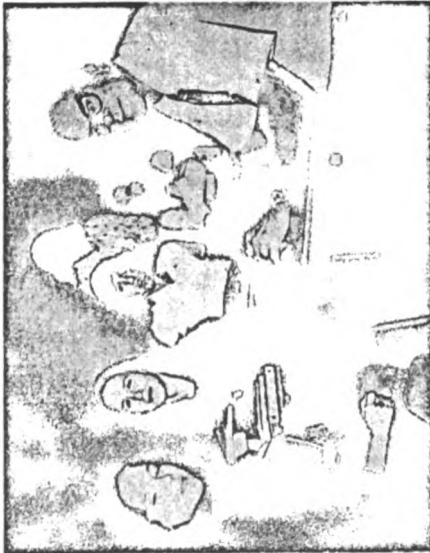
The divorce rate has also been about seven times lower among boys who took the course, compared with those who did not.

Since the early 1940s Keokuk High School and its family living teacher, James D. Lockett, who has been in sex education for 30 years, has kept track of divorce and illegitimacy among Keokuk students since 1947, and is convinced that the one-year sex education course he teaches is responsible for the lower rates.

"I teach about 10 per cent biology and about 30 per cent attitude," said Lockett. "The positive there is a relationship between the lower rates and the course."

Opponents of sex education argue that it will encourage "experimentation." They point to Sweden which has long had sex education but rising illegitimacy and venereal disease. In Keokuk, the opposite is true.

About eight out of 10 Keokuk girls have taken the voluntary sex education course since 1947. Lockett said that in the 22 years they had given birth to only 11 illegitimate babies among them. He said that the remaining two out of 10 girls who did not take the



James D. Lockett, family living teacher at Keokuk, Iowa, is shown with some of his students. Lockett, who says he teaches "about 10 per cent biology and about 30 per cent attitude," has kept track of his former students since 1947.

Emphasis on Attitude

course have had a total of 14 illegitimate births over the same period.

In the 22 years that were studied (1947 through 1969) about 1,300 girls, or 28 per cent, took the course. The 28 per cent who didn't take the course numbered about 40.

Lockett believes that the course gives students a sense of people caring what happens to them and not to have a baby gives a "bad deal" to them.

"Instead of increasing experimentation, the course may help students control their own

The goals in my teaching are to produce better interpretations of relationships and more stable, happy marriages. He tries to avoid being dramatic while discussing moral issues.

"I leave the final answer up to the students," said Lockett. "I tell them I won't be there and their parents won't be there when they have to make the decision."

The Keokuk sex education program had been in place in high school until 1946, when a Junior High program was begun. Next year a pilot program will begin in

The Kansas City Times

(The Morning Kansas City Star)

The Kansas City Star Company, Owner and Publisher

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Thursday, November 9, 1977

Mary Lee is a freelance writer who lives in Keokuk, Iowa.

the elementary grades.

There is a controversial State Department of Public Instruction course guide that recommends that sex education begin as early as kindergarten. Lockett agrees with this.

"In the first five years of school, they should learn that sexuality is good, they should learn the technical names of the body parts, male and female, and they should learn that sex is private but not shameful," Lockett said.

"If they learn that early, then we can do something about morals when they get to high school."

He measures part of the success of Keokuk sex education in divorce rates. He said that a study of boy graduates from 1947 to 1963 showed the divorce rate among those who took the sex education course was about 6 per cent. Among those who did not take it, the rate was more than 40 per cent.

In spite of this, Lockett said that he has not seen evidence that the sex education program was helping. "But parents are not de-

ing it," he added, "and we can't let it go by default."

More than 80 per cent of the students have reported that they got their sex information from some source other than their parents. "Perhaps some day, parents will do an adequate job of sex education," he commented.

Now the second generation is being taught by Lockett as some of his students are children of former students. He said that among children of former students only 10 per cent reported that they got their sex information from outside their homes.

"The indicated that parents who have had sex education are doing better. They are not taking the sex education course in school."

S O C I A L D E L I V E R A N C E S

184th General Assembly

The United Presbyterian Church in the United States of America

Denver, Colorado, May 16-24, 1972

Duplicated by
The Department of Church and Society
The United Presbyterian Church in the U.S.A.
830 Witherspoon Building
Philadelphia, Pa. 19107
June, 1972

UNITED STATES POPULATION POLICY
AND THE CHURCH

The Christian community must address itself to the problems of population growth and call the civil community to take such actions as will stabilize population size. Up to now, the church has not spoken with a "certain sound" to this major social issue, compared to its fervor and clarity regarding the agonies resulting from racism, war, poverty, etc. But the population problem is no less urgent.

It has taken 20 centuries to gain 3 billion people; present trends will give us a similar gain in the next 20 years. We soberly note that ever larger numbers of people are suffering as a result of crowded conditions, malnutrition, and inability to enjoy nature. Commodities formerly taken for granted and thought to be abundantly free are now scarce and precious--fresh air, clean water, and open space. Our present exceedingly consumptive life-style must be changed to bring into balance the biosphere. This will involve the development of new value orientations: (a) no longer equating bigger with better, and (b) envisioning man in a harmonious relation to the rest of nature.*

The life-styles we choose affect our fellow human beings and the whole environment. The average American puts at least 25 times as much stress on the environment in his lifetime as does the average child born in South Asia. The United States, for example, contains less than 6 percent of the world's people but consumes over 30 percent of its raw materials. Responsible man, as a part of nature and history, must be a steward of the planet for the living and for those to come.

The church is called to embody an "ethic of the future" attempting to avert a bleak existence for millions already living and seeking to enhance human freedom both now and for generations unborn.

If the church has contributed to the population plight, it has done so primarily through its support of medical services engaged in death control. The primary accelerator of population growth is decreased infant and youth mortality, not increased fertility. However, many people today, along with ancients, still face early death or fear genocide, and as an act of faith continue to have large families. We who are motivated by the urgency of overpopulation rather than the prospect of decimation would preserve the species by responding in faith: Do not multiply--the earth is filled!

The church should demonstrate a commitment to the reduction of family size. However, rather than dogmatically adopt a "stop at two" model, we seek an average of two children per family, which allows some to have more than two, while others may choose to have one or none. Such pluralism is not only ecologically sound, but it promises to be more socially just, in that it would not force any group to bear a disproportionate share of the burden of limiting population growth.

*Note 183rd General Assembly statement on Christian Responsibility for Environmental Renewal. (Minutes, 1971, Part I, pp. 574 ff.)

One of the major requirements of any population policy is that it be just-- i.e., that it treat all with fairness. This means that each person should be urged to limit his family size by making some sacrifice. It also means that minority communities should share in the development of population policy and programs and control programs that occur in their area. Furthermore, to be fair, family planning programs must provide not only information about limiting family size, but also provide the services to enable the poor as well as the rich to have real freedom of choice to do it.

But because of unjust policies and structures, some individuals and groups find their very survival threatened by starvation, sickness, and desperately inadequate living conditions. No population policy can be acceptable which depends on or tolerates such threats to security or survival.

Population policy is an integral aspect of social reform. It should dovetail with efforts to deliver educational and economic opportunities, as well as adequate medical care to those who are deprived of them. It is particularly fortunate that many of the great social reforms which are necessary to promote the general welfare and to which the church is already committed, will simultaneously work to curb population growth. The promotion of freedom and dignity for women, the establishment of minimal standards of economic well-being, the advancement of quality education for all, the improvement of health care (especially in areas with high infant mortality), and a more equitable redistribution of wealth and land will contribute to decreasing population growth rates.

Freedom (the capacity, opportunity, and incentive to make reflective choices and to act on them) is also a basic value to be served by population policy. God gives man and woman unique choices and powers to share in creating human life. Freedom is the primary basis of the responsible (planned) parenthood movement within the church and of the movement to liberalize abortion laws. Freedom is communal as well as individual. It is imperative that individual behavior be shaped by communal concerns and the requirements of justice, as well as by personal interests. While we do not believe that the population crisis has reached such a stage that individual freedom must be abrogated, we do believe it should be disciplined in light of our other values.

Believing that Christians must not ignore these grave issues, and recognizing the complexity of population questions as well as increased governmental interest in the formation of a population policy for the United States,* we, the 184th General Assembly (1972) of The United Presbyterian Church in the United States of America, favor the following population objectives and approaches:

I. Policy Objectives

A. For the United States

1. The United States should move as rapidly as possible, consistent with the values of our tradition to a stabilized population. We reject at this time the need for any coercive measures, and hold as an objective the preservation of individual freedom of choice as well as the promotion of justice and general welfare.

*E.g., the Family Planning Services and Population Research Act of 1970, and the Commission on Population Growth and the American Future which issues its final report in 1972 (See Appendix for list of Federal agencies in this field).

2. A population policy for the United States should be a part of an overall plan for changes which must take place in society in which major emphasis is given to racial equality, equality for women, promotion of quality education for all, development of an adequate and humane minimal income, as well as conversion to an ecologically sound communal understanding of man's relationship to man and creation.

3. A population policy for the United States should contribute to reducing pollution, natural resource consumption, and urban overcrowding. It should also help to preserve open space.

B. International Policy Objectives

1. The community of nations as a whole should slow the world's rate of population growth as soon as possible and stabilize it at replacement level. Policies and programs should provide special assistance to the poorer nations to develop their own economies and should contribute to a more equitable distribution of world resources and opportunities to help meet the needs of the already large population.

2. We should conserve the limited resources of our planet for the people alive today and especially for the larger numbers of future generations.

3. American assistance for international population programs should be channeled, whenever possible, through multilateral planning agencies.

II. Program Approaches

A. Regarding United States Domestic Policy

1. We urge Congress to establish a national policy of stabilizing population size as rapidly as possible, consistent with the values stated above. We call for strengthening of agencies and programs to carry out this policy. We are distressed at the low rate at which programs already authorized are now being implemented.
2. We commend to the government and the American people the desirability of reducing average family size and urge them to:
 - a. Examine all public policies for their pronatalist* implications, i.e., tax deductions for each child, changing policies that are found to be significantly pronatalist where it can be done equitably.
 - b. Change policies and practices which discriminate against females and which destroy personhood or deny them the right to choose fulfilling alternatives to motherhood.
 - c. Enact legislation continuing to protect all person's rights, but which will more easily facilitate intercountry and interstate adoption. We commend adoption to those who wish to and can care for larger families. We urge the United States government to permit tax deductions for the costs of adopting a child.
 - d. Refrain from legislation and policies which may imply a special concern for limiting the size of families of minority groups.
 - e. Provide educational and economic opportunities to those who are deprived of them, thus enhancing their freedom to determine their family size.

* To encourage birth.

- f. Support indigenous community leadership in developing their own ways of utilizing family planning resources.
 - g. Give critical study to the Report of the Commission on Population Growth and the American Future, and support to population policy recommendations that meet the church's criteria.
 - h. Be attentive to the reports of the United Nations Conference on the Human Environment (Stockholm, June 1972), supporting those recommendations that meet the church's criteria.
3. We urge public and private funding for research, even at the expense of other medical or technical research, into areas such as:
- a. Contraceptives that are inexpensive, effective, safe, convenient, and suitable to various moral and aesthetic desires of men and women of various cultures.
 - b. A simple economical and reliable self-administered pregnancy test.
 - c. Reversible sterilization.
 - d. Abortion methods.
 - e. Population distribution and the effects of crowding.
 - f. Reproductive motivation and life-styles or values that affect population-related decisions.
 - g. An equitable sliding-scale fee system for potential use in taxation or fee structures related to childbearing.
4. In a context of comprehensive health care programs, we call for provision of:
- a. Special services to those groups with high infant and maternal mortality rates.
 - b. Sterilization services regardless of the number of children born.
 - c. Readily accessible abortion services. (While abortion is not advocated as a general birth control method, it should be available at minimal cost and liability to those who become pregnant with an unwanted child.)
 - d. Readily accessible, contraceptive information and materials to all persons, including teenagers without parental consent, administered through responsible trained staff and at minimal cost.
5. We call for publically funded population education from elementary through graduate and professional school, encompassing at each level areas of sex education, conception control, interpersonal relationships, environmental concerns, and a "global" posture.

B. Regarding International Programs

- 1. We commend the United Nations Fund for Population Activities, the World Bank, World Health Organization, UNESCO, Food and Agriculture Organization, and other United Nations' agencies for international efforts in stabilizing population growth, and urge them to accelerate their efforts in the field.
- 2. We urge the United States Government, private agencies, and foundations, to increase support of programs around the world which will slow population growth and move toward population stability, and to channel a larger proportion of this aid through multilateral channels. This must be done in a manner that will provide full freedom and participation to the recipient nation and people.

3. We urge our government to recognize a responsibility for enhancing the educational and economic standard of underdeveloped nations, that they may be better able to establish alternatives to rapid population growth.

C. Regarding Church Policies and Programs

1. We commend an active initiation of or visible involvement with organizations striving to address themselves to stabilizing population size, i.e., vasectomy clinics, planned parenthood, sex education, environmental education, abortion counseling and referral, etc., at local, state, national, and international levels.
2. We urge an examination of the liturgy, study programs, and events of the parish to determine how population concerns may be infused into the total life of the church, i.e., preaching, church school classes, family night, couples organizations, and marriage counseling.
3. We recommend an examination of the church organization and program to identify pronatalist bias.
4. We urge support of local, state, and national legislative bodies working for the passage of legislation that will facilitate policies endorsed in this statement. Furthermore we actively solicit the cooperation of organizations that can help generate enabling legislation.
5. We urge the appropriate General Assembly agency to provide Biblical and theological background and study for this concern in the church's educational program at all age levels.
6. The world mission of our church should give greater emphasis proportionately to programs which contribute to the goal of slowing population growth, if necessary at the expense of conventional medical programs, but in a manner consonant with our church's commitment to the self-development of people. This would include not only family planning programs, but also greater opportunities for women and better child care. Wherever there is an opportunity, we should work with other denominations toward this end.
7. We encourage church agencies to award scholarships and to develop internship programs for research in the theology or science of ecology, with special reference to population policy.
8. We recommend that sessions and other judicatories communicate this policy to physicians, health care organizations, and community action leaders within their jurisdiction.

D. Regarding the Individual

1. We urge you, as citizens and church members, to work for the programs emphasized above.
2. Recognizing the need for an average of the two-child family and the need for all to make some sacrifice in this regard, we urge you to con-

sider having fewer children than you now contemplate having, even if you currently anticipate having only one or two. We suggest adoption, stressing that no child should be considered "unadoptable", as a means to establish or enlarge your family.

3. We encourage parents actively to participate in the sexual education of their children and to lead them toward a responsible sexual life.
4. We remind those beyond childbearing age that they also can contribute to stabilized population size in many ways, e.g., avoiding the grandparents syndrome which increases pressure for grandchildren.

E. At This Time We Reject

1. Reduction of the number of immigrants.
2. Flat-rate taxation on births or positive incentives for periods of not bearing children.
3. Compulsory controls upon any individual or segment of society regarding child-birth, including compulsory sterilization and abortion or compulsory use of antifertility agents.

F. Implementation of the Report

1. We recommend that this policy statement and accompanying background paper on United States Population Policy and the Church along with the 183rd General Assembly (1971) statement on Christian Responsibility for Environmental Renewal be published and distributed by the Office of the General Assembly for study and appropriate action.
2. We recommend that the formation of an adequate population policy be stated as a priority objective of the corporate church within its concern for environmental education and action. We urge that the General Council include Environmental Renewal, including population issues, in its More Urgent Concerns.
3. We ask the General Assembly to recommend to the Program Agency that it establish a Consulting Committee on Population Policy and Environmental Renewal to advise the agency in the implementation of the recommendations in this report.



BOARD OF WOMEN'S WORK

341 Ponce de Leon Avenue, Northeast
Atlanta, Georgia 30308
404-876-8821

Evelyn L. Green, *Executive Secretary*

Mrs. Bluford B. Hestir, Jr., *Director of Personal Faith
and Family Life*

June 1, 1973

The Honorable Alan Cranston
United States Senate
Chairman, Special Committee on Human Resources

Dear Sir:

I would like to register, for your committee, recent actions and statements of the Presbyterian Church in the United States which relate to our concern for the continuance and expansion of programs of family planning, specifically in S.1708.

In May of 1969 the following statement was adopted:

"To meet the clear call of God which we see in the faces of millions of starving people, the 109th General Assembly of the Presbyterian Church in the United States:

Declares that world hunger is so real and grave
that this problem is a top priority concern of
the Presbyterian Church in the United States and
that all possible resources of the church for at
least five years must be focused on ways and means
of dealing with this problem."

Unto this end a Task Force on World Hunger was formed to involve the million members of the church in the "War on Hunger". We have taken the position that the root causes of hunger may be divided into three categories; too little food, not enough money and too many people. Accordingly the church has taken further steps to support population education and family planning programs. For example, I serve for our church as a "religious advisor" to Planned Parenthood/World Population's National board. Through the Board of Women's Work, we encourage women to volunteer their services at Family Planning clinics; we have taught courses in the women's summer training schools in the fifteen southeastern states on the meaning of responsible parenthood, to the born and the unborn. We have contributed to the program of Planned Parenthood and given money to set up "Family Service Centers"(which include family planning services) in Zaire, Korea, and Taiwan.

Page 2

The Honorable Alan Cranston

The following further recommendations have been approved by the 110th and 111th General Assemblies along with a position paper on "The Population Crisis". (attached)

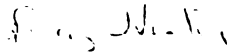
"Urge Presbyterian married (and to-be-married) couples of child-bearing age to begin seriously studying the implications of the population explosion for planning their own families.

Urge ministers especially to become aware of their grave responsibilities to be informed and to counsel couples in terms of limiting the size of their families as a Christian response to the growing problems of over population."

We have, just this week, held a "Consultation on World Hunger and Development" aimed at devising strategies for carrying this priority beyond the five year mandate. One entire section of the Consultation was concerned with the population problem, and the church's concern for women, especially in the south who do not have, or do not know about available family planning services. We are concerned that the programs be expanded to "make parenthood a happy choice, not an accident". This is because we believe that people are too important to be an accident.

I would like to add the voice of our denomination, which is concerned with the wholeness of human life, to the number of persons and groups which have spoken in support of S1708 and the continuation and expansion of family planning services.

Sincerely,



Mrs. Bluford B. Hestir, Jr.

LH/np
Enc.

The Population Crisis

The existence and growing urgency of a worldwide population crisis is by now well established, even though projections by authorities will understandably vary. As projected by some authorities:

— 8,000 babies are born every hour; 70,000,000 are born every year.

— At the present rate of growth (excess of births over deaths), the world population is doubling every 35 years.

— This means, barring such catastrophes as thermo-nuclear war, chemical and biological devastation, or massive international famine that by the year 2000 the world population will be nearly 7 billion; by the year 2035, 14 billion; and by the year 2070, 28 billion; or one hundred years from now there will be 8 people on earth for each one now alive.

Many Americans tend to think of this problem as limited to undeveloped nations, but the facts do not support that assumption.

— The annual net gain in U.S. population is more than 2 million.

— By the year 2000, or shortly thereafter, there will be more than 300 million Americans.

— If we were to accommodate the full increase in new communities, we would have to build a new city of 250,000 persons each month from now until the end of the century.

The worldwide implications are inescapable that given present rates of growth even the most drastic and heroic efforts to increase food production and to utilize fully all the earth's resources in meeting even the minimum survival needs will be inadequate. Along with this recognition, which has been voiced for several years, there is now the new awareness of the relation of population growth to the growing pollution of earth, air, and water and the increasing probability of severe ecological crisis. As Paul R. Ehrlich has put it: "the progressive deterioration of our environment may cause more death and misery than any conceivable food-population gap." Many problems are labeled "urgent" today, but none can be regarded as more desperately urgent than this.

A statement on population issued by thirty heads of state called the population crisis "a situation unique in human affairs and a problem that grows more urgent with each passing day."

Dr. Philip Handler, president of the National Academy of Sciences, has said that "the greatest threat to the human race is man's own procreation."

Moreover, Robert S. McNamara insists:

"What we must comprehend is this: the population problem will be solved rationally and humanely — or irrationally and inhumanely. Are we to solve it by famine? Are we to solve it by riot, by insurrection, by the violence that desperately starving men can be driven to? Are we to solve it by wars of expansion and aggression? Or are we to solve it rationally, humanely — in accord with man's dignity?

There is so little time left to make the decision. To make no decision would be to make the worst decision of all. For to

ignore this problem is only to make certain that nature will take catastrophic revenge on our indecisiveness."

The more pessimistic observers conclude that it is already too late to avert such catastrophes, and some are taking what A. V. Hill has called "the purely biological view that if men will breed like rabbits they must be allowed to die like rabbits. . . ." To fail to act in face of the population explosion would be to adopt by default such a morally and Biblically indefensible position.

Recent Actions of the Presbyterian Church US

In recent years the Presbyterian Church in the United States, through its General Assembly, has begun to address itself to the problem. In 1960, the General Assembly adopted this statement:

"The sexual relation is the creation of God and is not therefore evil in itself. Within the marital bond it is to be regarded not merely as a means of bringing children into the world but also as a divine provision for the mutual fulfillment of husband and wife.

"The God whose creative grace makes possible the blessing of children through marriage likewise vests man and wife with moral responsibility in the exercise of their procreative function. This responsibility is intensified today by what is known as "the population explosion" and the threats to human welfare it involves. The bringing of children into the world is a privilege not to be lightly or selfishly evaded by married couples. On the other hand, the responsibility of prospective parents obligates them to consider well how their children are to be provided with that which will make for their best physical, cultural, moral and spiritual development.

"If man and wife are not to be denied mutual fulfillment in the sexual relation, and if society is not to be penalized by the unplanned and irresponsible production of children, it will follow that access to information regarding the best methods of birth control is the right of all married couples, and the provision of this information the duty of a responsible society."

In 1969 and 1970 the General Assembly received and affirmed the intentions of overtures calling for church awareness of the population problem and involvement in the education of persons to respond to the crisis.

Finally, in 1970, the General Assembly urged "Presbyterian married (and to-be-married) couples of child-bearing ages to begin seriously studying the implications of the population explosion for planning their own families", and further urged "ministers especially to become aware of their grave responsibilities to be informed and to counsel couples in terms of limiting the size of their families as a Christian response to the growing problem of over-population."

These statements speak to the problem primarily in terms of family planning. They call on individual couples to make private decisions to limit their families. We must now recognize that reliance on individual desires and private

decisions to effect voluntary control, however well supported by information and means, will not be sufficient to provide the necessary limitation of population growth unless there is a radical and rapid change in the attitudes and desires.

The church must commit itself to effecting this change. The assumption that couples have the freedom to have as many children as they can support should be challenged. We can no longer justify bringing into existence as many children as we desire. Our corporate responsibility to each other prohibits this. Given the population crisis we must recognize and teach, beginning with ourselves, that man has an obligation to limit the size of his family.

In addition to adopting the above, the General Assembly also adopted the following:

The General Assembly of the Presbyterian Church in the United States, recognizing that the population explosion is a major cause of hunger domestically and internationally, urges Presbyterians at home and abroad to practice

responsible family planning; pastors to preach and counsel about this matter; couples contemplating marriage to consider limiting children to two; and if there be a desire for additional children, to adopt these.

The Presbyterian Church in the United States in this 111th General Assembly calls on all its boards, agencies, courts, and members to study and implement the position it has adopted in "The Population Crisis," and requests its Boards of Women's Work and Christian Education in particular to provide leadership in implementing this position.

The Presbyterian Church in the United States in this 111th General Assembly commends the United States Congress for enacting in 1970 the nation's first comprehensive family planning measure; commends all public and private efforts to encourage voluntary family planning; and call for more vigorous, better coordinated and more adequately-funded efforts to make available both the information and the means of birth control to all persons in this country, and, through cooperation with international agencies and the governments of other nations, to all persons in the world.

TESTIMONY OF
MARY ELLEN HAINES
Consultant on Family Planning
to the
Board for Homeland Ministries
of the
United Church of Christ

June 6, 1973

Senator Cranston and members of the committee, I am Mary Ellen Haines, consultant on family planning to the United Church Board for Homeland Ministries. I wish to briefly present the concerns of the United Church in the area of family planning, in relation to Senate bill 1708.

During the Eighth General Synod of the United Church of Christ, in June of 1971, the church supported a statement of Freedom of Choice in the area of family planning. In this statement the church "calls to action" all members, pastors, congregations and instrumentalities "to provide programs of counseling and education as to the meaning and nature of human life, sexuality, responsible parenthood, population control and family life".

"... to work for the expansion of family planning services in the communities they serve and to initiate new programs that can serve as models".
 "... to develop ministries on behalf of disadvantaged and minority groups which would give them freedom of choice in the area of family planning".

For the United Church, the issue of family planning is rooted within a total priority for economic justice. Hence, having the "freedom to choose" implies also contraceptive availability and education, regardless of age, marital or economic status.

With the development of a continuing program for family planning services, the Board for Homeland Ministries has increasingly supported a total concern for counseling, education, examination and dispersion of contraceptives within a community facility, as well as the training of local community members to work within that facility.

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Ideally, family planning is a concern of a whole family, a decision and responsibility fulfilled cooperatively. We urge the fulfillment of this ideal through greater efforts at involvement of single men, husbands and sons in family planning education.

Unfortunately, family planning, with the development of the most widely used contraceptives today, has laid the burden of decision and responsibility on women. With the development of the pill, the IUD and other methods, women were, for the first time, freed, in a relative way, to safely control their own bodies. Yet with growing respect and reverence for their physical well being, women realize the potential danger involved as well. Drug companies, doctors and clinics have had a lot of control over women's choice and acquisition of birth control methods. Much of the available information about effectiveness, safety, possibility of side effects, and reversibility of the different contraceptives is researched and published by the drug companies, who are interested primarily in sales. Each company in its advertising to doctors quotes the highest possible effectiveness rate for its product, and tends to gloss over or never mention side effects.

There is a great need for independent research on birth control methods: It has been shown that many of the "Independent" studies so favorable to the pill have been done by scientists and doctors actually financed by drug company grants.* Therefore, in supporting a position for the right to

* Health-Pac Bulletin (March 1970) p. 12. (Published by the Health Policy Advisory Center, Inc., 17 Murray Street, New York, N.Y. 10007).

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choose, the United Church must also emphasize "the right to know", not only that evidence which has been relatively conclusive or inconclusive, but all the specific evidence that may be of consequence to any one of us.

We therefore stress, in order that responsible and knowledgeable choices might be made, further research into the positive and negative effects of presently prescribed birth control methods, as well as the development of more satisfactory methods for both men and women.

Effective distribution and usage of family planning information and contraception requires a trustful rapport between community and staff in a local facility. We therefore urge the training of community members and especially women for positions in such facilities. Only those with a vested interest in the well being of women and a certain community can build such a working relationship. Such a situation is necessary for creating a true atmosphere of freedom of choice.

Additionally, we urge substantial representation of citizens on any governing board, and encourage the development of formal structures that would facilitate consumer participation on the local level.

It is also important to remember that counselors in family planning clinics, on college campuses for instance, have recognized that the greatest barrier to effective family planning education are attitudes toward sexuality. We live in a time of confusion, indecision and lack of direction or vision regarding our sexuality. Unwanted pregnancy is the sorrowful result of this situation. To obtain birth control is to admit that we are sexual beings,

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and lurking puritanism in our culture often does not allow us to admit this. Our continuing "romanticism" that interprets sexual relationships as passionate spontaneous occurrences and not premeditated, shrouds this original ambivalence. Education in sexuality may not be interpreted as a direct concern of S.1708 but it will be a crucial issue for family planning professionals in the future. These two issues of responsible parenthood and sexual ethics cannot be easily separated; therefore, the United Church urges any program dealing in family planning to address as well our society's sexual attitudes and to create an atmosphere where such problems might be dealt with adequately.

Lastly, I would like to emphasize those areas of S.1708 that the United Church would especially support.

In accordance with the church's Statement of Freedom of Choice, we wholeheartedly support the voluntary nature of the program.

Taking into consideration the special problems of rural and low income groups, we nevertheless urge that such a program be directed to all levels of the population, equally, and warn against attempts to lower the population growth of any poor or minority sector of the population.

The United Church encourages strongly all research in the biomedical, contraceptive development, and social science fields, and urge that the findings of such studies be made readily available to the public.

We believe the inclusion of service recipients on a national Advisory Council to be necessary, and recommend that participation by recipients in local programs be more than token and instead represent their substantial involvement on governing boards, as administrators and on all levels of staff.

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Finally, we call upon the national government to make family planning, in the context of preventive medicine and total health care, a higher priority, for it is the right of all persons, regardless of sex, age, marital or economic status. Toward this objective the United Church is actively supportive.

We believe that S.1708 offers a constructive step toward fulfilling this objective and urge its passage by the U.S.Congress.



Christian Life Commission

BAPTIST GENERAL CONVENTION OF TEXAS
206 BAPTIST BUILDING • DALLAS 1 • TEXAS

June 5, 1973

The Honorable Alan Cranston
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

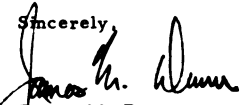
We want you to know of our strong support for your efforts to strengthen family planning services, planned parenthood education and contraception research through the Department of Health, Education and Welfare.

Enclosed you will find copies of statements by the Baptist General Convention of Texas and by the Southern Baptist Convention which indicate the strong support of Southern Baptists for responsible parenthood and the deep concern of Baptists for the population problems that confront our nation today.

We feel keenly that this historic Baptist position be rightly understood. Baptists have always magnified freedom and responsibility for family planning.

This is particularly important since Southern Baptists, the largest Christian body in the United States outside Roman Catholicism, have at times been misrepresented as opposing birth control, sex education, and the government's involvement in family planning services. We definitely do not oppose such programs; in fact, we strongly support them. In turn, we are grateful for your fine leadership in this national priority.

Sincerely,


James M. Dunn

JMD:lm

Enclosures

JAMES M. DUNN, SECRETARY
PHIL STRICKLAND, ASSOCIATE

"Convention Bulletin," 1972 Baptist General Convention of Texas.

Christian Life Commission Report

INTRODUCTION

Believability is essential in business, the mass media and politics. It is even more important to the Christian witness. As individuals and as the Baptist General Convention of Texas, we want the world to see that we set out our faith, to see that it is real. Our testimony to the transforming power of Jesus Christ must be believable. Texas Baptists have asked the Christian Life Commission, their social concerns agency, to speak to them on the application of the gospel to family life, race relations, citizenship, daily work, religious liberty and moral issues. Humbly, prayerfully, earnestly and with a sense of urgency the Christian Life Commission in this report focuses attention on grave moral matters.

Compassion for people compels us to speak. Honored stewardship of God's blessings will not permit us to be silent. An effective Christian witness demands believability.

FAMILY

Families are in trouble. Almost 800,000 divorces are granted each year. Separation, desertion and severe marital unhappiness are common.

Some researchers conclude that approximately 70 per cent of all Americans have intercourse prior to their marriage. Other studies state that at least one out of every six brides is pregnant at the time of her marriage. According to sociologist Robert Bell, about 30 per cent of all married women and possibly 60 per cent of all married men have committed adultery by age 40.

When the human suffering, the tragedy, the sin, the lost contribution to the Kingdom of God reflected in the above statistics are considered, an obvious question is, "How can churches ignore an emphasis on family life?" The Bible does not ignore the family. The first chapters emphasize marriage, parenthood, sibling rivalry and husband/wife conflict. Family relationships are emphasized throughout the Old and New Testaments.

Therefore, it is imperative that the church of Jesus Christ make a concerted effort to participate openly and realistically in preventive and crisis ministries to families. Sermons, Sunday School and Church Training curricula, revivals, retreats, banquets, workshops, seminars, pre- and postmarital counseling and camps all lend themselves to sharing Christian insights regarding what family relationships ought to be.

While the above are ministries to be developed within the local church, Christians should also be concerned about political decisions which affect the family. Title II of the Family Code will be presented to the Texas Legislature in 1973. This Code, among other provisions, would make the father of an illegitimate child equally responsible with the mother for the child's support. Texas and Idaho are the only states without such a law. This reportedly would save taxpayers \$30 million annually in welfare payments. The Code also would prevent the tragedy involved when a mother changes her mind and takes back the baby she has given up for private adoption. The natural parents' rights would be severed before rather than after adoption.

Some young people have been committed to reform school simply because they were noisy, hook-poking adolescent runaways. The new law would make it impossible to commit a youth to reform school for merely troublesome behavior.

Many small children have been deliberately burned, beaten, degraded and otherwise abused by sadistic parents with records of abuse. Title II of the Family Code would allow a child to be removed from a home at the first sign of abuse rather than after he was seriously injured.

In essence, the Code would protect those who cannot protect themselves: children, like the ones Jesus protected.

Another matter of grave concern in Texas Baptists has to do with responsible parenthood. In the light of the growing population, the Christian Life Commission urges Baptists to take family planning seriously. In the United States, approximately 44 per cent of all births are unplanned and 15 per cent are unwanted at the time of conception.

Many should have the right to be wanted and loved. Ideally, children should not be "accidents," but the result of a deliberate choice made by a married couple, convinced that this is the will of God for their lives. Likewise, people have a right not to have children without being accused of selfishness or a betrayal of the divine plan.

The Christian Life Commission has always given the family high priority and continues to do so. Our 1973 Workshop, Feb. 26-28, will be devoted entirely to an emphasis on the family. A new series of literature containing 21 titles on the family will be ready for circulation by Jan. 1, 1973. The Baptist General Convention of Texas also has recognized the need for ministry to families, especially church staff families, with the establishment of the office of the Coordinator of Counseling Service and its program.

We believe that the gospel — the good news — should radically affect how husbands and wives, how parents and children, how single adults relate to one another. We equally believe that Christian families are the cement which hold our society together.

CRIMINAL JUSTICE

Texas are faced with a tragic paradox and a glaring injustice. Those who may be innocent and those who are convicted of lesser crimes often suffer far more punishment than those in the state penitentiaries who have been convicted of major crimes.

In Texas, great progress has been made in recent years in the state Department of Corrections. Comparable progress has not been made in county and city jails. Today, they may be the most primitive, disgraceful institutional facilities in our state.

One of the major problems in many facilities is overcrowding. In some of our major cities, jails are jammed with hundreds more than they were designed to care for. Many jails are antiquated. Solitary confinement cells have been found to lack drinking water, light, bunks and toilet facilities.

Exercise and recreation facilities are almost nonexistent. Prisoners in local jails may literally spend years confined to their cells without anything to do but read or play cards or dominoes. Only three per cent of Texas city and county jails have educational facilities. Seldom are there any programs of rehabilitation or education.

Most local jails do not separate prisoners. The person convicted of a felony and awaiting appeal is lumped with the youngster awaiting trial for a misdemeanor even though Texas law requires segregation of those awaiting trial and those convicted of offenses.

Amazingly, only 38 per cent of city and county jails have medical facilities, ranging from the excellent to the very poor. Tragic deaths due to lack of adequate medical attention happen all too often.

We are faced with the reality that many of our jails, designed to hold lawbreakers, are themselves in violation of the law by falling short of the minimum standards required by law.

It is shocking to realize that the majority of those who suffer under the substandard conditions of our local jails have not at that time been found guilty of any crime. Seventy per cent of those in city and county jails have not been convicted, and approximately twenty per cent have not even been arraigned. Thousands languish in our jails because they are too poor to make bail and not because they have been found guilty. Some of these await trial for as long as five years. If one is poor, he may wait in jail for years for his guilt or innocence to be established.

MINISTERS COUNSELING SERVICE

James L. Cooper, Coordinator
603 Bank Tower, Exchange Park
Dallas, Texas 75238
Phone 4-21-4357-3012

The Convention action of 1971 establishing the office of Coordinator of Counseling Services was put into effect on July 15, 1972 when James L. Cooper assumed this position, having been elected in May by the Executive Board.

A network of over 100 counselors has been established to whom referral can be made. These counselors are psychiatrists, counseling psychologists, pastoral counselors, etc. who have an understanding of and appreciation for a minister's theological background. Funds are available to supplement the counseling fee in cases where help is needed. In the first three months eight people have been referred for counseling and scores of others have been interviewed.

The ministry offered by the Counseling Service is to the healthy as well as the sick. In this light two growth retreats have been held for ministers and wives. Three continuing growth groups for staff members and two for ministers and wives have been established.

In cooperation with the Christian Life Commission two minister and wife workshops have been held which dealt with stress in the ministry and how to handle it.

The Coordinator has been across the state speaking to ministers groups in an effort to inform them of the ministry offered and to gain information about acceptable counselors.

The response has been encouraging and the need for this ministry, both to the sick and the healthy, has been more than verified.

Sisemore Speaks

The new director of Texas Baptist Sunday School Division challenged messengers attending the annual sessions of the Baptist General Convention of Texas to be leaders in outreach, Bible study and witnessing.

Dr. John T. Sisemore, who recently assumed his duties with the BGCT, urged Texas Baptist churches to enroll 50,000 new members in Sunday Schools during the coming year "for the Glory of Christ."

Sisemore was presented to the messengers Wednesday night at Taylor County Coliseum by Dr. Charles McLaughlin, secretary of the State Missions Commission.

Later, he was honored with a "get acquainted" reception at Hardin-Simmons University's Moody Center.

Sisemore told the messengers his "primary commitment" is to the "lordship of Jesus Christ."

He said, "My fullest commitment is focused on outreach, Bible study and witnessing. I believe these matters are God-given priorities for me and I must give my priorities to them."

Sisemore said he plans to make a strong effort to understand the needs of older persons and the young people of today.

Another highlight of the state missions report was recognition of Dr. C. Wade Freeman, director of the evangelism division, who has completed 25-years service with the BGCT.

PLANNED PARENTHOOD

1970 Annual, Baptist General Convention of Texas, p. 94.

1970

POPULATION - The population explosion is considered by many to be a survival issue. Either the world practices limited population growth or else it will create unimaginable human misery.

Having children is a stewardship, and should not occur carelessly or irresponsibly. Baptists should not only support family planning but also encourage responsible parenthood in light of limited personal and national resources.

Your Commission has attended and participated in several statewide conferences relative to population growth, and has offered testimony before state and national legislative bodies.

1969 Annual, Baptist General Convention of Texas, p. 89.

1969

PLANNED PARENTHOOD

Last year Texas Baptists, as a people who respect the dignity of man and acknowledge his freedom of choice, heard a plea to endorse the right and responsibility of family planning. To implement this concern we call on Texas Baptists to lend their support to the passage of United States Senate Bill 2108. This bill would expand, improve, and better coordinate the family planning services and population research activities of the Federal Government.

1968 Annual, Baptist General Convention of Texas, pp. 105-6.

1968

PLANNED PARENTHOOD

Baptists must face realistically and study diligently the practical problems and the personal dimensions of the population explosion. Every hour world population grows by 5,000 persons. Every day at least 10,000 die of malnutrition. Every week the tide of people rises by more than a million. We must recognize that much help for those in desperate human need is nullified by the continued population increase and that many children being born into the world are unwanted, uncared for, undernourished and underprivileged.

We call upon Baptists who respect the dignity of man and acknowledge his freedom of choice candidly to endorse the right and responsibility of family planning. Full family life education must be available to all citizens, particularly to the poor and uneducated. An affirmative public policy regarding birth control information is required in order that the right of free choice in the private life of husband and wife has basis in fact rather than being an empty slogan. We see any system, religious or political, that supports a mandatory, state-imposed ignorance of modern medical advances as dictatorial and inhumane.

Therefore, we support the programs of the Public Health Service and other government and private agencies that offer health and hope to mothers otherwise trapped in a cycle of annual pregnancies. We see that planned parenthood practiced in Christian conscience, may fulfill rather than violate the will of God.

Religious Action Center

UNION OF AMERICAN HEBREW CONGREGATIONS

2027 MASSACHUSETTS AVENUE, N.W., WASHINGTON, D.C. 20036. TEL. (CODE 202) 367-2800

June 20, 1973

RABBI RICHARD G. HIRSCH, Director
MARVIN BRATTERMAN, Counsel
and Director of Education and Research

The Honorable Alan Cranston
Chairman, Subcommittee on
Human Resources
Senate Committee on Labor and
Public Welfare
Washington, D. C. 20510

Dear Senator Cranston:

In Bishop James Ault's testimony before your subcommittee on May 8, 1973, he indicated that a representative of the Union of American Hebrew Congregations could not be present to present oral testimony on S. 1708, but that we would submit a written statement.

Enclosed is the statement of our organization in support of S. 1708, the Family Planning Services and Population Research Amendments of 1973. Please include this statement in the record of the hearings on that bill.

Sincerely,



Marvin Bratterman

cf
encl.

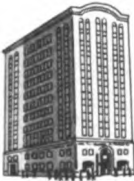
CC: Senator Jennings Randolph
Senator Gaylord Nelson
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The Religious Action Center, housed in the Emily R. and Elvira Kaplan Building, is under the auspices of the Commission on Social Action of Reform Judaism, a joint instrumentality of the CENTRAL CONFERENCE OF AMERICAN RABBIS and the UNION OF AMERICAN HEBREW CONGREGATIONS with its affiliates—National Federation of Temple Sisterhoods, National Federation of Temple Brotherhoods, National Federation of Temple Youth.

Statement of
UNION OF AMERICAN HEBREW CONGREGATIONS
to
Special Subcommittee on Human Resources,
Senate Committee on Labor and Public Welfare
IN SUPPORT OF
S.1708, Family Planning Services and
Population Research Amendments of 1973

June 20, 1973

The Union of American Hebrew Congregations (UAHC), founded in 1873, is the federation of over 700 Reform Jewish congregations throughout the United States and Canada. Throughout its 100 years of existence, the UAHC has expressed an overriding concern for the principles of social justice, especially as these tenets serve to preserve individual freedom and dignity for all people. One's freedom is realized as people have equal right and opportunity to use and obtain the benefit of the medical, technical and social changes that are available through the enlargement of the frontiers of science and knowledge. One of the most important of these rights, and one often neglected, is the right and opportunity to plan family size -- predicated on personal, psychological, social, economic and religious factors according to the needs and wishes of individuals voluntarily expressed.

Because family planning services have not been provided for many families, too many have been denied this voluntary opportunity and right. The Family Planning and Population Research Act of 1970 began to rectify this problem. The amendments to that Act, embodied in S. 1708, will go a long way toward improving that innovative beginning.

- 2 -

Jewish tradition and law emphasize the sanctity of human life. Such sanctity requires the use of knowledge and services that offer the prospect of a healthy and prosperous life. One of these services is providing information and medical assistance in the planning of families, a concern which has long been on the agenda of the UAHC.

At its 45th Biennial General Assembly in November, 1959, the UAHC adopted a resolution entitled "Favoring Dissemination of Birth Control Information," which said:

the failure of large sections of our population to plan their families effectively is due neither to conscience nor to free choice, but rather to legal and official obstacles imposed upon many Americans with the result of depriving them of knowledge and medical assistance in this field.

In 1965, at its 48th General Assembly, the UAHC reaffirmed its 1959 position on family planning in these words:

We believe that the dissemination of birth control education for family planning is not an infringement of civil liberties nor an attempt to act in ways prejudicial to the interests of any racial, ethnic, religious or cultural group, but on the contrary, we believe planned parenthood is for those who desire its vital contribution to responsible family life.

The Family Planning Services and Population Research Amendments of 1973 serve to tighten, strengthen and enlarge the Act of 1970 and provide the necessary rudiments to carry out the objectives of the five year plan (and its subsequent updates) submitted to Congress in October, 1971. S. 1708 calls for the provision of family planning services to those who could not otherwise afford them. Of equal importance, the new amendments would increase research in the areas of human reproduction and contraception. We applaud especially those provisions of S. 1708 which expressly

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safeguard the rights and integrity of individuals, by emphasizing the strictly voluntary nature of family planning programs and the integration of such services with other health programs.

While the Act enhances the individual opportunity for family planning, the aggregate social value of such services should not be overlooked. The family unit is the foundation of our society. Its well-being in all segments of our population is vital for a stable and productive society. We must ensure against involuntary and fortuitous growth rates which lead to overpopulation and that leave too many of us in an anti-social competition for finite resources. The right of every human being to a life of dignity depends on the quality of the total human society, at least as much as the quality of life in his or her own home and family.

We gladly support the proposed Family Planning Services and Population Research Amendments of 1973 and we urge the Committee to report this legislation favorably and to promote its passage without delay.

Respectfully submitted,


Marvin Braiterman
Counsel

Sen. Alan Cranston
c/o Senate Office Building
Washington, D.C.

May 31, 1973

Thomas W. Hilgers, M.D.
1117 4 1/2 St. N.W.
Rochester, Minnesota 55901


Dear Sen. Cranston:

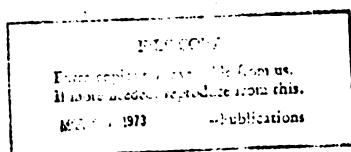
I would like to enter the enclosed scientific paper THE INRAUTERINE DEVICE: Contraceptive or Abortifacient? as testimony in the current hearings you are holding on federal monies for birth control devices.

This paper was written for the seminars in obstetrics and gynecology sponsored by the Mayo Graduate School of Medicine. It was presented in the fall of 1972. It is a unique study in that it canvasses all of the research that has been done on human subjects wearing intrauterine devices. As such, it is the only such study of its kind available. Currently, it is being prepared for publication in MINNESOTA MEDICINE.

As you will be able to see, the paper concludes that the IUD is an ~~abortifacient~~ device. I hope that this will be of value in the deliberations of your committee in view of present law.

Thank you very much.

Sincerely,

Thomas W. Hilgers, M.D.
Fellow, obstetrics and gynecology
Mayo Graduate School of Medicine



THE INTRAUTERINE DEVICE: CONTRACEPTIVE OR ABORTIFACIENT?

Thomas W. Hilgers, M.D.

Resident in Obstetrics and Gynecology

Mayo Graduate School of Medicine

(University of Minnesota)

Rochester, Minnesota

Presented at a seminar in obstetrics and gynecology on October 17, 1972. This paper prepared under the supervision of members of the faculty of the Mayo Graduate School of Medicine.

Research has shown that intrauterine devices (IUD) have an anti-fertility effect in every animal species tested. However, the mechanism through which such devices interrupt the reproductive process seems to differ from one species to another.¹ It is not possible, therefore, to explain the mode of action in a manner that applies to all species studied. Furthermore, the differences in the anatomic and physiologic features of the reproductive system among animals make it difficult, if not impossible, to arrive at conclusions applicable to man yet based on studies of animals.¹ Although much research has been done on rats, rodents, rabbits, sheep, cows, and monkeys, it can only give certain clues of what to study in the human being. Any direct comparison between man and animals, therefore, is always of questionable relevance.

This discussion will be devoted to the extensive research that has been conducted in human beings. As far as is known, no such review has ever been undertaken. Animal studies will be mentioned only when they seem particularly pertinent from a historical or scientific viewpoint.

Historical Introduction

Intrauterine devices have allegedly been in use to control fertility for more than 2,000 years.² For centuries, Arabian and Turkish camel drivers have inserted a small round stone, the size of a kidney bean, into the uterus of their

saddle animals prior to a desert trip.³ This has been said to repulse the advances of the male as if the female were pregnant.⁴

In 1909, Richter,⁵ a German physician, first described the insertion of two or three strands of silkworm gut into the human uterus for birth prevention. His work went almost unnoticed.

In 1916, Dickinson⁶ predicted that a simple, safe, and effective intrauterine device eventually would be adopted for purposes of birth control.

It was not until 1928, however, that the modern history of IUDs began. In that year, Gräfenberg,⁷ a Berlin physician, reported on the insertion of silkworm gut stars, later to be supplanted by silkworm gut rolled into rings and bound with silver wire, as a means of intrauterine birth control. In 1929, he⁸ reported on 2,000 insertions of his new device. He found a 1.6% failure rate and no signs of the device causing inflammation of the uterus. His results were significant since later reports of similar results became the springboard for the present use of IUDs.

An early enthusiast of this method of birth control,⁹ Leunbach, of Copenhagen, inserted 175 rings over an 8-month period in 1929 and 1930. His enthusiasm waned, however, and he rejected the device as harmful and unreliable.¹⁰

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 Later Haire, a follower of Gräfenberg, "...used the ring for a number of years, but 'because of the possibility that it may be an unsuitable method, in a considerable portion of women' he did not recommend it in his last article written shortly before his death....". The condemnation of the Gräfenberg ring by both Haire and Leunbach is noteworthy from a historical perspective because they had actual experience with the device. 12 Tietze wrote that condemnation came only from those who had never had such experience.

In 1940, in a speech before the Obstetrical Society of Philadelphia, Kimbrough and Tompkins 13 stated on the basis of "dozens of unfavorable reports, the use of an intrauterine foreign body...as a 'contraceptive' is regarded as dangerous practice if not malpractice." This was the state of things until 1959.

In 1952, the Rockefeller Foundation founded the Population Council, whose proposed purpose was to study 14 population growth and to finance studies in reproduction. This marked the official entrance of Rockefeller money into the fight to control fertility. Today, the Population Council is described as a private American foundation supported by the Ford Foundation, the Rockefeller Foundation, John D. Rockefeller III, and substantial private and

government donations. From 1953 to 1964, the Council put
over \$20 million into their work.

In 1957, Alan Guttmacher was approached by
Mr. Daniel O'Connor, an economic advisor to the government
of Puerto Rico, about the use of the IUD, but Guttmacher was
not receptive because he thought the IUD too dangerous. In
1959, Dubrow and Guttmacher wrote in a review of contraceptive
methods: "Intrauterine devices are mentioned only to be thoroughly
condemned [emphasis added] because of their ineffectiveness,
their potential source for infection and irritation, as well as their
carcinogenic potentialities."

At that time, because no American physician could
be found who had personal experience with the method and who
was willing to report on it, the editors of the American
Journal of Obstetrics and Gynecology invited Dr. W. Oppenheimer
of Israel to contribute an article on the subject.
Oppenheimer's contribution coincided with a paper from Japan
by Ishihama. Guttmacher wrote later that "after this many
physicians changed their attitudes and became more tolerant
toward the concept of intra-uterine contraception." Because
Oppenheimer's and Ishihama's reports were said to show that
the IUD was safe, effective, and reliable, the door was
opened for a "reevaluation."

The impact of these two studies on the medical acceptability of the IUD was evidently rather noteworthy. Unfortunately, the advocates were careless in their reading, for nothing new or revolutionary had been added to the already existent knowledge. Oppenheimer's report is the most glowing report ever written on the IUD. The author was overwhelmingly complimentary and his statement that in his experience of 866 insertions he considered "the method absolutely harmless" is a claim that was never before made and has never been made since. Quite frankly, Oppenheimer's assertion has never been substantiated in the countless number of similar studies done both before and after his report.

¹⁷ Ishihama also reported his extensive experience with the IUD in 1959. His results were really no different from those reported previously and, in fact, may have been somewhat worse than what Gräfenberg originally reported. Nonetheless, it was on the basis of ^{7,8,18} two reports, one of which was solicited, that the Population Council began to make its decisions and to influence the world's use of this device.

In January and February, 1962, Guttmacher ⁴ was sent by the Population Council and the International Planned Parenthood Federation to study conception control around the

world. When he returned to New York, he advised the⁴ Population Council that the "best chance for immediate success lay in work with intrauterine contraception," an astounding suggestion from the same man who only 3 years previously had soundly condemned such practice.

In spite of the obvious contradictions from Guttmacher, the Population Council followed his advice and held the first International IUD Conference April 30 to May 1, 1962.¹⁹ The meeting was attended by 40 people from 11 countries.⁴ The Second International Conference on Intrauterine Contraception was held in New York October 2 to 3, 1964, and was attended by 500 participants from 44 countries.⁴

In this latter conference discussion was begun on the abortifacient capability of IUDs. Candidly expressing that an abortifacient label would be detrimental to promoting the device in underdeveloped countries like Pakistan, where abortion is strongly opposed, the population planners began to redefine abortion and pregnancy.²⁰

In considering redefinition, the likelihood that IUDs destroy blastocysts prior to implantation led the planners to consider defining the blastocyst out of existence. Pregnancy, they said, should be redefined to begin at²⁰ implantation. It seems that all subsequent scientific

conferences on the "Preimplantation Stages of Pregnancy"²¹
 were to be considered mere fiction.

Later, a scientific group of the World Health Organization (WHO) gave careful consideration to the proper name for these devices.²² After considering such names as "intrauterine foreign body" (IUFB), "intrauterine contraceptive device" (IUCD), and "intrauterine device" (IUD), they unanimously accepted the name "intrauterine device" (IUD) with the recommendation that it be universally used in the medical literature. However, most articles in the literature, written primarily through grants from the Ford Foundation and the Population Council, have ignored this recommendation and continued to use ^{intrauterine contraceptive} device. This rhetorical ploy is in direct contradiction to the mounting scientific evidence that the principal mode of action of the IUD as a "contraceptive device" is not the prevention of conception but, rather, the destruction of the human blastocyst prior to implantation.²³⁻³⁵

Action of the IUD

Intrauterine devices used in humans are generally composed of stainless steel or mixtures of polyethylene and barium sulfate.⁴ The barium is added to make them radiopaque. Those being fashioned from plastic tubing can, as a result, be stretched into linear form and threaded into a Teflon tube. This catheterlike tube, with the bore of a soda straw,

can be passed through the cervical canal just beyond the internal os; a plunger is then inserted to force the device into the uterine cavity. Since moulded plastic has "memory," the device can be reshaped into its original form after being discharged into the uterus. Today, well over 70 different models of IUDs are available and they are being used by more than 10 million women.

Other substances have been explored for use within the uterus to prevent pregnancy (e.g., copper and zinc). However, since these are not being readily used and are not yet licensed by the FDA, this review will be limited to the so-called inert IUDs (i.e., IUDs made of inert substances like plastic or stainless steel). However, as pointed out by this review, these substances are far from inert.

Effects on Menstrual Cycle and Ovulation.---Most investigators agree that the IUD does not interfere with or inhibit the process of ovulation in any way. It has been shown also that the menstrual cycle is normal in length in women with IUDs. This finding has been confirmed by endometrial biopsies and visualization of corpora lutea at laparotomy, as well as by histochemical studies of the ovaries.

Interesting in this light, however, is the work of Faucher et al. They noted that the postovulatory phase of the menstrual cycle was shortened in four of six patients

studied and that the urinary pregnanediol was decreased in all six patients.³⁸ This could indicate impaired function of the corpus luteum and might implicate a luteolytic function to the IUD. If this were true, it might also implicate a role of prostaglandins in the mechanism of action of the IUD. Such a theoretical possibility has been mentioned but as⁴³ yet it has not been investigated. If such a process occurs, it would disturb the precise balance that is necessary for implantation.

Chronic Endouterine Infection

The possibility that chronic endouterine infection may play a role in the mechanism through which the IUD works has been investigated. Microscopic changes in the uterine lining, previously thought to be associated with chronic infection (chronic endometritis), have been reported to occur in varying degrees. A Japanese study reported 74% of patients wearing IUDs had signs of acute inflammation while only 19%⁴⁴ revealed signs of chronic inflammation.

Most American studies have focused on the incidence of a chronic inflammatory process in response to the IUD and these results indicate that 13 to 28% of women with IUDs^{42,45,46} have chronic endometritis. One study from Taiwan placed the incidence as low as 1.7%,⁴⁴ but this is truly out of line with other similar studies.

When other investigators have attempted to determine if this inflammatory reaction is due to infection, they have concluded that it is not. In a study of 200 patients Willson et al.⁴² found that the presence of the IUD did not significantly alter the bacterial flora of the endometrial cavity. Mishell et al.^{47,48} found some cultures to be positive immediately after insertion of the device, but all of the endometrial cavities examined 1 month later were sterile.

The inflammatory reaction observed in about 20% of patients is not thought to result from infection but rather from a reaction of the endometrial lining to the chronic presence of a foreign body.⁴¹ In any event, the endometrial lining in these patients is altered appreciably from the normal and it is conceivable that this disturbance may prevent the blastocyst from implanting.⁴⁹

The Role of the Fallopian Tube

The role of the muscular activity of the fallopian tube has also been studied extensively although inadequately. In the normal, nonpregnant woman without an IUD, the muscular activity of the fallopian tube tends to be low in the preovulatory phase of the menstrual cycle.⁵⁰ After ovulation, the tubal peristaltic activity tends to increase while the uterus is quiescent. When the corpus luteum regresses, the tubal activity evolves into a typical menstrual pattern with

outbursts of increased activity occurring at short intervals.⁵⁰
 It is due to this diversity of effects that transportation
 of the blastocyst by tubal peristalsis is accomplished while
 the uterus rests.⁵⁰

In 1965, when Mastroianni and Rosseau⁵¹ reported that
 the presence of the IUD in superovulated Macaca mulatta monkeys
 was associated with rapid discharge of the ova from the tube
 to the uterus, the thought that IUDs in some way abnormally
 increased the muscular activity of the fallopian tubes
 became the commonest theory of how the IUD functions.
 Mastroianni and Rosseau gave monkeys gonadotropins so that
 they would ovulate at a predictably higher rate. Shortly
 thereafter, Kelly and Marston⁵² reported that the transport of
 ova through the fallopian tubes of normally cycling rhesus
 monkeys was not affected by the presence of a foreign body in
 the uterus. It seems that Mastroianni and Rosseau's technique
 of giving their monkeys gonadotropins stimulated the tubal
 activity that they originally reported. In 1967, Mastroianni
 et al.⁵³ repeated their study in normally cycling monkeys without
 exogenous gonadotropin stimulation and obtained the same
 results as Kelly and Marston. This put to final rest the
 idea that increased tubal activity was the prime mechanism
 by which the IUD exerted its effects.

The actual role of the fallopian tubes is difficult
 to state precisely at this time. The studies have been few
 in number and generally of poor quality.

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In 1964, Siegler and Hellman reported the cases of three patients on whom they conducted uterotubal insufflation after 2 months' use of an IUD. Only two of these patients were in the postovulatory phase of the menstrual cycle and their results indicated that no mechanical obstruction of the tubes existed. This series was much too small to permit any decisive conclusions regarding tubal physiology in the presence of the IUD.

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Ishihama et al reported a similar investigation of 30 patients before and during insertion of the IUD. They found no remarkable difference in tubal activity between the two groups. They also reported their findings on tubal transport of a radiopaque dye that had been inserted into the tube and then observed via cinesalpingography. In their opinion the presence of the IUD did not strongly influence the muscular contractions of the fallopian tube.

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In 1970, Makhoul and Abdel-Salam reported their studies of uterotubal insufflation in 100 women 5 days after menstruation. They found that the strength of tubal contraction was increased significantly over and above that of the control group in 96% of patients and that, in accord with this, the number of peristaltic waves was increased in 88% of their patients with IUDs. These changes persisted and actually increased the longer the IUD was in place.

This was a well-controlled study, but it was done on women during the fifth day after menstruation or during the preovulatory phase, and these times are not applicable to the mechanism of action of the IUD.

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In 1971, Kamal reported his results on uterotubal insufflation in 50 patients, some of whom had had an IUD inserted for 2 to 3 years. He found definite impairment in uterotubal function presenting as spasm of the uterotubal junction or the isthmic portion of the tube. These changes returned to normal after the IUD was removed, which indicated that the IUD was the cause. Unfortunately, no mention was made of the time during the menstrual cycle when these observations were obtained.

While the specifics of tubal physiology in the presence of the IUD are still somewhat undefined, the work of Noyes et al. sheds definite light on the role of the tubes and the action of the IUD. In an exhaustive search for ova in the human uterus and tubes, they recovered 11 eggs from 92 patients fitted with IUDs and only 12 from 161 women without IUDs. This difference was not significant on chi-square analysis. It would appear that the tubal transport of eggs is not appreciably affected by the presence of an IUD.

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The Role of the Myometrium

In the preovulatory phase of the menstrual cycle in the nonpregnant woman without the IUD, the muscular activity of the uterus tends to increase progressively with a period of stabilization just prior to ovulation. Shortly after ovulation, there is a period of 2 to 5 days of uterine quiescence. During this time, implantation is possible and if it occurs, uterine quiescence is maintained by the corpus luteum of pregnancy. If implantation does not occur, then uterine activity evolves progressively into the pattern of exaggerated muscular activity which is typical at the time of menstruation.

The action of the uterine musculature in the presence of the IUD is considerably clearer than that of the fallopian tube. Johnson et al. reported on 32 patients in whom they measured intrauterine pressures by the open-end catheter technique of Hendricks. This study had many drawbacks and their conclusion that no increase in uterine muscular activity occurs in the presence of the IUD is highly questionable in view of later reports.

In 1967, Bengtsson and Moawad reported on a well-controlled series using Hendricks' technique. They found that in women with IUDs, prelaborlike uterine contractions begin 4 to 5 days after ovulation and progress to full

laborlike contractions during the menstrual period. This activity is clearly abnormal and coincides with the transport and implantation of the blastocyst. They felt that this may play a part in the mechanism of action of the IUD.

Using a totally different technique, Behrman and ⁶¹Burchfield reported in 1968 and Behrman et al, ⁶²reported in 1969 that, after ovulation, the uterus entered a period of complete quiescence lasting until 24 hours before the beginning of the next menstrual cycle. The differences between their results and the results of Bengtsson and ⁶⁰Moawad probably were due to the differences in the sensitivity of the two techniques. The transducer IUDs used by Behrman et al probably responded to only local changes in muscle activity, while the catheter system of Bengtsson and Moawad measured changes in the cavitory pressure produced by the ⁶³entire uterine musculature.

In 1970, Moawad and Bengtsson reported on the ⁶⁴long-term effects of the IUD on uterine musculature. In women who had been using the device for at least 3 years, they again found prelaborlike contractions beginning 4 to 5 days after ovulation. These were not encountered in patients who were not wearing IUDs.

These studies have now been confirmed by the ⁶⁵Japanese who also found prelaborlike contractions in the postovulatory phase in patients with IUDs.

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Serr et al. found increased electric activity of the uterine musculature during the postovulatory phase in patients with IUDs. This activity, which probably indicates increased uterine muscle activity, was not seen in controls.

In summary, the evidence seems to be strongly in favor of some significantly increased uterine muscle activity in patients with IUDs during the time when implantation would occur. This disturbance may indeed lend itself to an interference of the implantation process.

Effects of Intrauterine Devices

On Sperm Migration.--In 1964, Malkani and Sujan⁶⁷

did hysterectomies on four patients who had been wearing IUDs for 10 days. All had had coitus the evening before the operation. In all four patients, active sperm were found⁶⁸ around the IUD and in the fallopian tubes. Morgenstern et al. corroborated these findings in a similar study of 13 women. These patients, however, had been wearing the IUD considerably longer than the group of four. Morgenstern et al. concluded that the chronic presence of an IUD does not prevent transport of spermatozoa to the site of fertilization in the fallopian tubes. They did find a low sperm concentration in the tubes, but concluded that this is similar to what is expected in women without IUDs.

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Brown and Allen artificially inseminated 12 patients, 6 with IUDs and 6 without, a few hours before hysterectomy.

In all 12 patients, active sperm were found in the fallopian tubes. They concluded, as did the other investigators, that the presence of an IUD does not prevent the ascent of sperm to the sight of fertilization. Kesseru-Koos⁷⁰ also observed this pattern of sperm migration and no one has described contrary results.

On Fertilization.--There is no evidence that the IUD consistently prevents fertilization. On the other hand, it seems likely that fertilization occurs with normal or near normal frequency in the presence of the IUD. Noyes et al.³⁰ recovered a fertilized egg in the pronuclear stage from the right tube of a patient wearing an IUD who had had coitus 2 days prior to hysterectomy. This, in conjunction with the numerous intrauterine pregnancies that have been observed in the presence of an IUD (Table 1), proves that conception can indeed occur.

⁹⁰Virkar reported the case of a woman who had intercourse with the IUD in place. Shortly afterward, she had the IUD removed and an implanted pregnancy ensued. He stated that "this case nicely brought out the fact that ovulation and fertilization are not interfered with, but it is the process of implantation that is affected by an intra-uterine device." Other investigators⁶⁰ have reported the same observation.

It has been observed that the incidence of tubal pregnancy in a given population of women wearing IUDs may be somewhat less than one might anticipate; however, the ⁹¹ number of intrauterine pregnancies is, by comparison, greatly decreased. This fact suggests that the primary action of the IUD is at the uterine level. ³⁴ If the process of fertilization were inhibited, an equal decrease in the number of tubal pregnancies might be expected. Since this is not the case, we can only surmise that fertilization takes place regularly and that the primary action is a postconception, intrauterine one.

On the basis of direct intrauterine observation with the glass fiber hysteroscope in 55 patients wearing IUDs, ³¹ Sakurabayashi et al. concluded that the "fertilized ovum" was rapidly expelled from the uterine cavity. They observed that if the IUD was fitted well into the upper part of the uterine cavity no uterine implantation occurred although implantation was observed in the fallopian tube. Only when the IUD had displaced itself to the lower portion of the uterine cavity was implantation observed, and then only in the upper portion of the uterine cavity. This most unusual study seems to implicate a directly mechanical component to the mode of action of the IUD. This would seem likely in view of the ⁹² observation that the efficacy of a given IUD is directly proportional to its size and surface area.

30

Marston, Kelly, and Eckstein found that, in monkeys, there was no difference between control and IUD study groups in the rate of occurrence of fertilization. The fact that fertilization was not disturbed in the presence of an IUD established that transport of the sperm was adequate and its capacitation was not hindered. They did find that fertilized eggs entered the uterus normally and once the eggs were in the uterine lumen they seemed to undergo rapid degeneration. This study is thought to be of particular importance because of the close anatomic, physiologic, and phylogenetic relation between monkeys and human beings.

⁹³
Of Phagocytosis.--In 1968, Virkar and Kelkar first reported the existence of large numbers of active, multinucleated histiocytes in a study of 10 loopal smears.

⁹⁴
 In the same year, Israel, also from India, reported a much larger series of 228 loopal smears in which she found only 55 containing multinucleated histiocytes. She also studied 65 endometrial aspiration smears taken immediately after removal of the IUD. None of these smears revealed multinucleated histiocytes. The majority of her patients were long-term users of the IUD.

In 1970 attention was called again to these ⁹⁵⁻⁹⁷ phagocytic cells in a study of 37 loopal smears. Sagioglu and ^{these cells} Sagioglu noted that / were numerous and most of them were

small and monocytic shortly after insertion of the IUD. Only after the IUD was present for longer periods did they note the larger, multinucleated cells.⁹⁵ Contrary to Israel's report, this was a consistent finding.⁹⁵ They also noted some phagocytosis of sperm. Some workers have interpreted this to be the mode of "contraceptive" action of the IUD. However, the Sağıroğlu also noted the "collective phagocytosis" of a giant material (thought to be an ova or blastocyst) by the macrophages. This finding, it seems, was most significant because they outlined as follows the ways they thought the macrophages created a hostile environment mainly for the fertilized ova.^{95,98}

- (1) With the presence of the IUD surrounded by millions of macrophages in the endometrial cavity, the fertilized ova will not find hospitality, but hostility.
- (2) Macrophages, like biologic foam, cover the surface of the endometrium and isolate it from the blastocyst, thus preventing implantation.
- (3) When a fertilized ovum, as a giant foreign body, enters the endometrial cavity, the macrophages actively move on and isolate it from the endometrium by a firm phagocytic siege.
- (4) Macrophages liberate an enzyme, protease. The protease content of uterine fluid is increased twofold in the presence of the IUD. This is significant since the enzyme protease is a powerful lytic agent.

The zona pellucida, the insulator and protective membrane of the ova, and then the blastocyst may be dissolved or degenerated by this enzyme. (5) Spermatozoa are also foreign bodies. In the presence of IUDs, the millions of macrophages may incapacitate some of them.

It has been shown that the primary cell type in the endometrial aspirate of women with IUDs is the neutrophil and not the macrophage.^{34, 99} Moyer and Mishell³⁴ think this indicates that neutrophils are more diffusely distributed throughout the uterine cavity while the macrophages are more adherent to the plastic IUD.

This intrauterine cellular reaction, which is^{23, 94, 99, 100} evoked by the IUD, has been observed in all animal species.

²³ Segal stated, however, that it is "...inadequate to create a spermotoxic environment but sufficient to prevent nidation of normal blastocysts arriving, on schedule, from the oviducts."³⁴ This is supported by the fact, as Moyer and Mishell pointed out, that the cellular degeneration products of neutrophils and macrophages are "injurious to the unimplanted embryo."

¹⁰¹ On Sperm Capacitation.--Rosado et al observed a significantly increased concentration of calcium in the human endometrium of females wearing an IUD. They hypothesized that this may inhibit the capacitation process. Interestingly enough, these changes were observed in biopsy samples of the

endometrium and therefore do not reflect the environment through which the sperm traverse to meet the ovum.

¹⁰²
Kar and co-workers have observed a similar increase in the calcium concentration in the endometrium of monkeys. Since it has been shown that capacitation is unaffected in the monkey, ³⁰one can assume that this calcium plays no significant role.

On the Endometrium.--Results of studies on the endometrium with the IUD in place have been somewhat confusing and contradictory, perhaps because the material for study in the majority of cases was obtained from endometrial biopsy. This presents a major source of error in sampling because biopsies from a given site may not reflect the pattern of the endometrium as a whole; also, it is a blind procedure and one cannot be certain of the actual source of the specimen. ⁴⁵

Nonetheless, agreement is general that the IUD causes transient inflammation, with increased vascularity, some hemorrhage, and edema of the area of the endometrium that is in direct contact with the IUD. ^{24,25,41,42,46,103-106}In conjunction with this, it has been shown that in some cases the IUD imbeds itself deeply or even buries itself in the endometrium. This area underlying the IUD shows evidence of pressure atrophy with ^{41,105-109}compression and fibrosis.

Many studies have been conducted to determine if the IUD in any way interferes with the normal synchrony.

Some reports have indicated that there is no phase discrepancy in the presence of the IUD. ^{16,109} Many more investigators, using light microscopy, have reported a delay in the histologic maturation of the endometrium. They have found a preovulatory ^{24,26,27,42,44,103,106,110,111} type of endometrium in the postovulatory period. These changes seem to be particularly obvious in that area of the endometrium that is in close contact with the IUD. ^{26,106}

^{24,25} Wynn, using the electron microscope, described changes in the ultrastructure of the endometrium which would indicate premature maturation. He found ultrastructural changes that were characteristic of those found several days later in the normal endometrium. (He found a well-developed nucleolar channel system in epithelial nuclei in about 20% of preovulatory endometria, and predecidual changes in about 25% of specimens as early as 19 to 20 days. The synchrony, furthermore, often ^{25,103} affected the stroma more than the epithelium. ^{26, Japan,} Tamada et al, in/ ¹⁰⁸ found similar results. Wynn and Sawaragi while they have stated that/ interpreted their findings as a premature ultrastructural development, the alternative explanation would be retardation of histologic development. In either case, the evidence strongly suggests a disturbance in the synchrony of the endometrial and ovarian development that is normally ¹⁰⁸ required for implantation.

On the Endometrial Fluid.--The fluid or exudate that lies within the endometrial cavity surrounding the IUD makes up the milieu to which the blastocyst must enter. The biochemistry of this fluid is interesting.

The volume of the fluid is greatly increased in women fitted with an IUD, and especially in those who have symptoms such as pain, discharge, or bleeding after its insertion. This alone has been thought to be an impediment to blastocyst implantation.

The pH of the fluid has been found to be decreased in one study and unaltered in another.

Karetal, consistently found large increases in the protein and nonprotein nitrogen concentration in IUD-fitted women irrespective of the stage of the menstrual cycle. The nonprotein nitrogen was primarily urea. In general, these increases were thought to lead to an increase in osmotic pressure of the fluid rendering the milieu unfit for survival of the preimplantation blastocyst. More specifically, urea is known to be disruptive to proteins, and excessive quantities of urea in the uterine fluid of women fitted with the IUD are almost certainly detrimental to the viability of the preimplantation blastocyst.

Further biochemical changes also have been detected. Persistence of positive staining of the mucopolysaccharides

of the ground substance with alcian blue up to day 20 to 24 of the cycle represents a failure of their depolymerization and this may decrease the receptivity of the endometrium to the blastocyst.^{29,109}

When the three sugars--hexose, hexosamine, and hexuronic acid--were studied, the results suggested that the IUD shifted the normal metabolic pattern of the endometrial mucosubstances. This may indicate a suppressive effect of the IUD on glycogen biosynthesis. This, too, is important in the antifertility action of the IUD.^{116,117}

In an absolutely classic study of the biochemistry of the human endometrium, Joshi and Sujan-Tejuja,¹¹⁸ from India, conducted quantitative assays on a large number of women with and without the IUD in order to establish basic cyclical patterns. They studied the quantitative differences in deoxyribonucleic acid (DNA), ribonucleic acid (RNA), tissue protein, alkaline phosphatase, and acid phosphatase.

The normal changes in concentration of RNA, DNA, and total protein are considered to be indicators of the action of estrogen and progesterone on the growth of the endometrium.¹¹⁸ A comparison of these growth-activity indicators revealed that endometrial growth during the preovulatory and early postovulatory phases is actually stimulated by the presence of the IUD. Moreover, the peak concentration of RNA

in the endometrium, which normally is not attained until day 16 to 20, actually was reached during days 9 to 13 in the presence of the IUD, indicating an acceleration of growth. Higher concentrations of RNA and total protein in the endometrium of women using an IUD were found to be maintained even during days 21 to 24 when the growth activity of the normal endometrium is significantly suppressed.¹¹⁸

Alkaline phosphatase and acid phosphatase activity also showed an increase. The increase in alkaline phosphatase activity probably reflects the participation of this enzyme in tissue growth.¹¹⁸ The increase in acid phosphatase, a hydrolytic enzyme, was thought to represent an increase in lysosome function.¹¹⁸ Lysosomes generally are considered to participate in intracellular and extracellular digestive processes.

Miscellaneous Effects.--Some investigators have detected a prolonged or elevated secretion of the pituitary hormone oxytocin¹¹⁹ while others have noted elevated blood levels of this same hormone in women who use IUDs.¹²⁰ This may indicate some systemic effect of the IUD as opposed to a completely local effect, but the actual significance of these findings still is not well understood.

Implantation in the Presence of the IUD

In any analysis of the IUD in which an attempt is made to reach conclusions on either its contraceptive or its

abortifacient nature or both, one must look carefully at those cases in which implantation is known to occur in the presence of the IUD. The outcome of these pregnancies is of considerable significance.

Table 1 is a list of the individual and cumulative experiences of 18 different investigators reported in the medical literature. These studies were randomly selected. The only selective criteria were the accuracy with which the investigator reported the total number of pregnancies, the number of spontaneous abortions, and the number of ectopic pregnancies that occurred with the IUD known to be in place.

In more than 151,000 woman-months of use, there were 273 pregnancies with the IUD known to be in situ. Fourteen of these were still in progress at the time the author reported his findings, but were here assumed to have gone full-term. Of these 273 pregnancies, 78 (28.6%) ended in spontaneous abortion and 23 (8.4%) ended in ectopic pregnancies. Therefore, a total of 37.0% of all these pregnancies ended in fetal death.

This percentage of "fetal wastage" is significantly higher than in women not wearing IUDs. The normal incidence of spontaneous abortion is thought to be at least 15% of all pregnancies between the 121-123 fourth and 20th weeks of gestation (Table 2). The incidence

of ectopic gestation in the white, middle class population of the United States is approximately 0.3% (1:330) and in the medically indigent, it is no higher than 1.0% (1:100).¹²⁴ It is the contention of this analysis that the substantial and only difference between these two groups is the presence of the IUD and, therefore, the increase in fetal loss is directly attributable to the presence of the IUD.

Others have found similar results but have not taken this direction of thought. Their own data, however,¹²⁵ substantiate this claim. Tietze and Lewit, reporting on 782 uterine pregnancies in more than 261,689 woman-months of use, found that 41% of 542 pregnancies with the device known to be in situ ended in abortion. Perkin¹⁵ reported that 36.4% of pregnancies occurring with the device in situ ended in abortion. (The number of pregnancies was not stated in this report, but it represented a substantial experience of 85,782 woman-months of use.)

Both of these reports stated that their data do not indicate the incidence of induced abortion. However, of the 240 pregnancies that occurred in Tietze and Lewit's series in which the device was not recovered,¹²⁵ only 33% ended in abortion. And in Perkin's study,¹⁵ only 25.8% of those in which the presence of the device was "unlikely" aborted. Given a distinct separation into two groups, one

with IUD and one without, the latter should serve as an inbuilt control series, for the pregnancies would be no less distressful than the ones with the IUD in place and the pressures to artificially abort would be the same.

In the simultaneous presence of an IUD and an implanted pregnancy, one can expect that in at least 10% of all pregnancies, spontaneous abortion will develop because of the mere presence of the device. However, the percentage may be and most likely is considerably higher than that. The absence of the device was never substantiated in either ^{and Lewit's} Tietze / or Perkin's series and, therefore, an untold number may have aborted as the result of the hidden presence of an IUD. One must also take into account the tubal pregnancies (3.4%) that result in de facto fetal destruction. This ^{32,91,126} increase in tubal gestation has been reported by others as well.

In support of this concept, Tischler and Kraus¹²⁷ reported a case of spontaneous abortion in which the IUD had entangled itself in the umbilical cord and was thought to be the cause of fetal death.

In reality, the thought that a mechanical object in the uterus may be a cause of spontaneous abortion is nothing new in medicine. The presence of a naturally occurring mechanical obstacle, such as a submucous myoma, has been ¹²⁴ known to be a cause of habitual spontaneous abortion.

In addition to all of this, if an IUD is inserted into an already pregnant uterus, it has been shown to cause an extremely high rate of spontaneous abortion. Also, if an IUD is removed from an already pregnant uterus, there is a substantial increase in the rate of spontaneous abortion.⁷⁹ Many such abortions have been reported.^{79,80,128}

Summary and Conclusions

An evaluation of the studies that have been conducted/to elicit the mechanism through which the IUD exerts its effects allows one a better understanding of its mechanism of action. This review represents that kind of exhaustive effort.

It is certain that the IUD provokes a myriad of unnatural effects on the female reproductive system. These effects, working in unison, undoubtedly contribute to its ultimate action.

The IUD does not interfere significantly with the menstrual cycle, with ovulation, or with sperm migration. This appears well settled. There seems to be little question that active sperm, in adequate numbers, do reach the fallopian tubes where fertilization normally takes place. No evidence at the present time suggests that fertilization itself is prevented consistently. On the contrary, all available evidence strongly supports the concept that fertilization occurs at normal or near normal frequency.

Present knowledge indicates that the mechanism of action of the IUD is focused in the uterus. The effects exerted by the IUD on the endometrium, on myometrial activity, and on the intrauterine biochemical and biological milieu are destructive in nature, and under these conditions, the preimplantation blastocyst is unable to survive.

One cannot say that the IUD always destroys the blastocyst since a number of live-born babies with IUDs implanted in their placentas speak against that. At the same time, one cannot say that fertilization always occurs, for certainly one could make a case for occasional prevention of conception. Nevertheless, given today's knowledge, it is evident that the IUD exerts its birth-preventative effects primarily through the destruction, at a uterine level, of the preimplantation blastocyst. In addition, it is clear that the IUD, in the small number of cases in which implantation is allowed to occur in its presence, is a frequent initiator of the abortive process and, as a result, well-developed fetuses are aborted.

In light of current, accepted medical definitions of contraception, abortifacient, pregnancy, conception, and abortion,¹²⁹ the conclusion is that the primary action of the IUD must be classed as abortifacient.

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Investigator	Year reported	Device used	Woman-months	Total pregnancies,		Spontaneous abortions	Ectopic pregnancies
				IUD in situ			
⁷³ Webster	1971	Loop	3,190	4		2	1
		Saf-t-coil					
⁷⁴ Doyle et al.	1970	Loop	16,992	18 (5)*		3	0
		Spiral					
		Coil					
⁷⁵ Kellander	1970	Spiral	1,716	4†		2	2
⁷⁶ Vaughn and Dominguez	1970	Saf-t-coil	Not stated	11		3	2
⁷⁷ Solish and Hajdin	1969	Spring	12,408	14		5	0
⁷⁸ " "							
⁷⁹ Viestale et al.	1969	Loop	1,902	9† (3)*		4	1
⁸⁰ Horne and Scott	1969	Loop	7,714	4†		2	1
		Spiral					
⁸¹ Hall	1968	Loop	21,350	53		23	4
⁸² Bolognese et al.	1969	Bow	18,348	44		5	0
		Loop					
⁸³ McCann	1967	Row	4,393	8		2	0
⁸⁴ Graham et al.	1967	Saf-t-coil	2,460	4 (1)*		3	0

⁸¹ Bolognese et al.	1968	Dow	19,848	44	5	0
		Loop				
⁸² McGannon	1967	Dow	4,303	8	2	0
⁸³ Cheatham et al.	1967	Saf-t-coil	2,460	4 (1)*	3	0
⁸⁴ Ringrose	1967	Loop	10,840	16	4	2
⁸⁵ Waintraub	1967	Ring	12,821	41	12	2
⁸⁶ Blott and Radcliffe	1966	Spiral	Not stated	7 (3)*	3	0
⁸⁷ Lippes	1966	Loop	21,909	23 (2)*	3	4
⁸⁸ Willson et al.	1965	Spiral	5,606	6	Not stated	3
⁸⁹ Jessen et al.	1963	Ring	1,252	5	2	0
⁸⁹ Hall and Stone	1962	Ring	6,396	2	0	1
Total			151,481†	273 (14)*	78	23
Percent of total pregnancies					28.6%	8.4%
Combined percentages						37.0%

*Numbers in parentheses indicate pregnancies in progress. The number is included in the total number.

†Additional pregnancies terminated by legal abortion. The numbers were not included in the total number because the outcome was unpredictable.

‡Total woman-months is greater than is shown because the numbers were not stated in two studies. Blott⁸⁶ and Radcliffe alone reported 1,884.

Table 2.--The Risk of Spontaneous Abortion in Pregnant Women

Investigator	Year	Percentage of spontaneous abortions
Warburton and Fraser ¹²¹ 122	1964	15
Erhardt 123	1963	18
Tietze	1953	14

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Pennsylvanians For Human Life
Box 1622 Allentown
Penna.

This testimony is to be filed regarding Population Bill submitted to Senate 4/24/73

Hearings were held on 5/8,5/9,5/10.

This bill would consolidate provisions of Title X Public Health Service and P.L. 91-572 Family Planning Services and Population Research Act of 1970. It also would establish a new office to coordinate these policies. There are also some miscellaneous provisions that must be noted.

Enclosed besides a short statement are several items to be considered as part of the testimony filed by PHL .

we are concerned with the government of the United States making as their public policy laws concerning birth control and abortion. Private decisions on the matter of fertility control are one thing but government authorization is another.

I would hope the members of the committee would take into consideration the statistics and alternatives filed by other pro-life groups that show how the situation truly is and what the true solutions are. There would be no advantage in my going over these at this time. Some are in the enclosed items.

The points I wish to make are:

1. If population education is to be intergrated into E.P.A. programs all the different viewpoints must be expressed. Our children must be given all the facts in the case. This has not been the case in past situations. If we truly are a democratic society ~~and~~ faction must not force their ideas on others under the pretext of government support.

2.

2. As part of any government sponsored program the alternatives to abortion must be given equal time and money . This has not been the case in past years. There is a great deal of prenatal research that has suffered because of abortifacient research getting more than was necessarily called for. There is a whole range of birth controls techniques that could be perfected. Such agencies as Child Life Centers could be set up. Both sides of the coin must be inspected and utilized.

In your consideration of this vital issue I would hope the members of the commission would be truly sensitive to what their constituents want- freedom to make their decisions without government control.

PENNSYLVANIANS FOR HUMAN LIFE
P.O. Box 1622
Allentown, Pennsylvania

Dear

Pennsylvanians for Human Life is an organization of concerned citizens of our state. Its corporate purpose is to promote respect for human life in all its stages. It seeks to achieve this through educational means.

PHL is a nonsectarian group. Its most immediate concern is to promote a prolife atmosphere within a society that has been threatened by antilife abortion liberalization.

We are sending you articles and information that we hope you will find of interest.

If we can be of any other help please let us know.

Sincerely,

Are people pollution? Is there "standing room only" on the earth? Should we "make love, not babies"? Is Zero Population Growth an urgent necessity? Will our grandchildren starve to death unless every couple "stops at 2"? 2

The population "crisis" has reached panic proportions in this country, and in the panic, few voices seem to be asking: Is it really so? How serious is our population problem? Are extreme and immediate measures necessary to curb births and protect our national welfare? Present outcries are for a more direct and influential--perhaps even coercive effort on the part of government to reduce birthrates.

The recent summary report of the National Academy of Sciences, Rapid Population Growth, states, however, that "It is possible to take a different view, based on what we know about the history of human populations, and on the behavior of many people at the present time---a view that social inventions will lead to deliberate limitation of fertility by individual couples."

Let us consider, objectively, the question of population, the related issues of environment, natural resources and food supply, and the growing specter of enforced "life control."

PEOPLE ON THE LAND

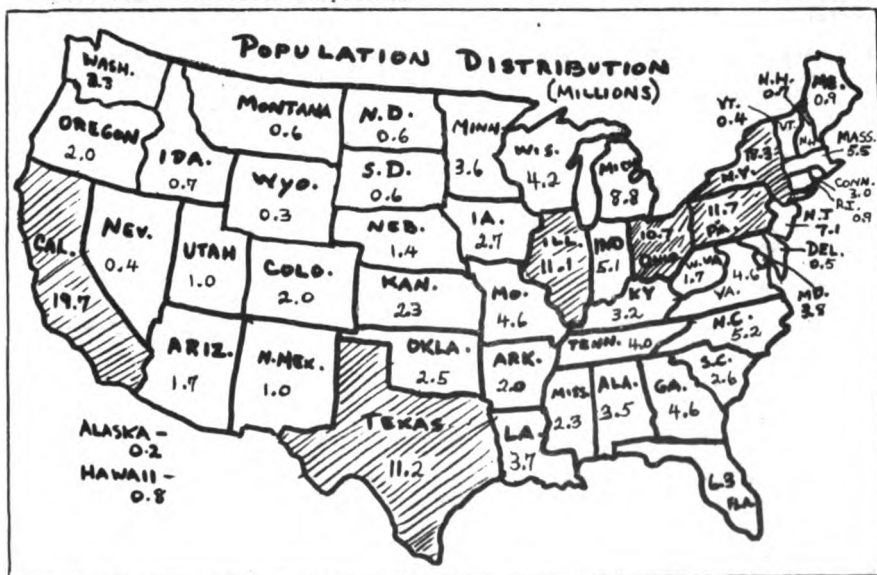
According to the 1970 Census, there are now approximately 203-million people living in these United States. Our total population is spread on a land area of 3,613,123 square miles, which works out to a density of 57 persons per square mile. For many of us, this figure means very little, and it helps us gain perspective if we compare it to other nations:

<u>WORLD-WIDE POPULATION DENSITY</u>		
<u>COUNTRY</u>	<u>PERSONS PER SQUARE MILE</u>	<u>COMPARED TO U.S.</u>
United States	57	--
Mexico	60	Slightly higher
Nigeria	174	3 times higher
Red China	197	3-1/2 times higher
Switzerland	382	7 times higher
India	413	8 times higher
England	588	10 times higher
Japan	708	13 times higher
Nationalist China	810	14 times higher
Holland	982	18 times higher

Certain large countries have a lower population density than ours (Russia--29 persons per square mile; Canada--3 p.s.m.; Australia--2 p.s.m.) but these nations have vast areas of vacant or uninhabitable land, and/or are less technologically advanced than the United States. Density, as such, is not an indication of overpopulation. Actually, our nation is proportionately populated: six per cent of the world's people occupying six per cent of the world's total land area.

Population expert Donald J. Bogue of the University of Chicago suggests that our total population can be "twice what it is now without much difficulty", and it would help considerably if "the cities of this country can be greatly decentralized."

Here, then, is a real difficulty: our population is very unevenly distributed. The fact is, 80% of our total population of 205-million people live on only 10% of the land! Nearly 70% are jammed onto 2% of the land. On the other hand, only 5% of the people live on that 49% classified as "farmland", much of which is not in production because of mammoth food surpluses.



Our heaviest population centers are concentrated in six states, each of which has over 10-million people. These states--New York, California, Illinois, Pennsylvania, Ohio and Texas--total 85-million people. This means that well over one-third of our entire population lives in six of our 50 states!

At the other extreme, 13 states have less than one-million people each, and four of these states lost population in the 1970 census. Half of all the counties in our nation also lost people in the last 10 years.

Rather than a population problem, we have a distribution problem. Rather than a population explosion, we have an urban implosion; huge

concentrations of people in small areas. If you live in an urban area, bumping shoulders and fenders with a million other human beings, it isn't surprising if the population crisis seems very real to you. Tremendous stress is placed on housing facilities, schools, highways, public transportation, electricity, water supplies, and just plain air to breathe.

WHAT TO DO ABOUT IT????

Suggested means to ease these conditions have included the development of a network of planned cities in underpopulated areas, and financial incentives to industry to locate away from major industrial--commercial centers.

Far more drastic measures are heralded, however, and these are aimed at curbing the total growth of population rather than simply redistributing it. These measures include:

--A national policy of zero population growth (balanced births and deaths), plus development of the means to achieve it.

--Removal of tax disincentives for all children beyond the first two.

--Mandatory contraception or sterilization for those too poor to support their families.

--Education in contraception for all teenagers.

--Repeal of all laws against abortion so it can be used as a back-up birth control method.

--Easier divorce laws and fewer restrictions on deviant sexual behavior such as homosexuality.

--A vast educational and informational program to sell Americans on the two-child family. As one advocate suggests, the government will have to "step in and tamper with religious and personal convictions and maybe impose penalties for every child a family has beyond two."

Other means include the suggestion to place a sterilizing chemical in the public drinking water, and a bill in the Hawaii state legislature to force sterilization on every woman giving birth to her second child.

Presently, there are over 40 bills and resolutions on population control pending in Congress.

Why are such extreme measures being advanced? Who pushed the panic button?

The American public, fed a barrage of information as well as propaganda, suddenly has become aware of some long-standing realities and some very real and urgent problems.

Birth-rates (number of children born per 1,000 population) shot up from a depression low in 1936 of 18.4 to a peak of 25.3 in 1957. If this trend had continued, we would have had more than 400 million people by the year 2000.

It is this projection to which Americans are reacting today. What they haven't yet realized is that a decline since 1957 brought birth-rates to their lowest point in American history--17.6 in 1968. The birthrate rose slightly in 1969 (17.8) and 1970 (18.3), but in the first eight months of 1971, dropped sharply again.

Government figures show there were 2,356,000 births from January through August, 1971, a drop of 3 per cent from the previous year. This was especially significant because the number of women of child-bearing age increased about 3 per cent in the same period. A high birthrate had been expected because the "baby boom" children are now beginning to reproduce themselves.

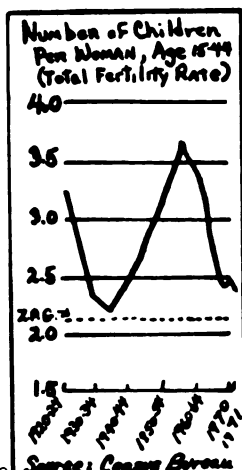
Other recent developments:

--A report of the National Fertility Study indicates there is a rapid and sharp drop in the number of children women intend to have. Women in their late 20s now expect to bear an average of 2.53 children--compared to the 1965 figure of 3.03. Demographers say this change alone could result in much slower population growth.

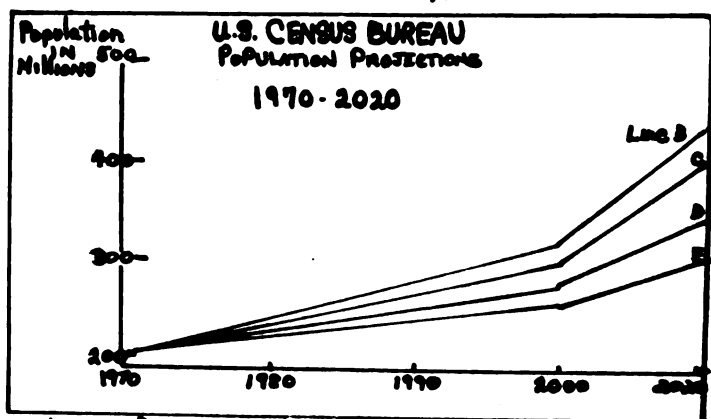
--A Gallup poll shows that in 1967, 40% of Americans favored four children or more; today only 23% do. Family planning, working wives, divorce, later marriage, economic pressures, women's liberation, etc. all have affected attitudes toward large families. Many experts see this as the most significant factor in future population trends.

--A striking increase in the number of young women who remain single was reported by the Census Bureau in November, 1971. Now almost half of women aged 21 are single, compared with one-third in 1960. Furthermore, 45% of women under 35 are single. The Census Bureau says these findings indicate that many young people are postponing marriage until older. But also this may demonstrate "a newly-developing tendency for more of the young persons of today to remain single for their entire lives."

--The Washington Center for Population Studies reported there are 15 1/2% fewer children under 5 years old today than 10 years ago.



Census Bureau projects a population as much as 100-million people less in the year 2000 than forecast three years ago. Expectations now: between 266 and 281-million by the turn of the century.



Line B - 3.1 child per woman - 324 mil. in 2000 (1950 rate)
 Line C - 2.75 child per woman - 301 mil. in 2000 (1970 rate)
 Line D - 2.45 child per woman - 281 mil. in 2000 (today's rate)
 Line E - 2.1 child per woman - 266 mil. in 2000 (replacement)

WHAT ABOUT OTHER PROBLEMS?

Experts point out that the serious pollution-resources problem is only indirectly related to population. Rather, it has to do with life-style. We have only six per cent of the world's people, yet we consume 40% of the world's goods! Rapid and disorderly technological growth and irresponsible industrial practices are the chief causes of the ecological crisis. The automobile alone causes 60% of our air pollution.

The N.A.S. notes that: "There is little doubt that, at least in the developed countries, sheer numbers are not nearly as important in causing pollution as are the high levels of consumption and the by-products of a highly-developed and diversified technology."

Harvard scholar Arthur Dyck has stated: "Our life style must change. If we stayed at 200-million, would air pollution decrease? Would other problems ease off? No. We have to change our values, our behavior."

Agricultural economist Colin Clark maintains that the U.S. population could continue to increase at its present rate until the year 2000 and there still would be large surpluses.

From the N.A.S. Report: "From a worldwide view, divergent resources utilization and population trends suggest that, to the end of the century, and probably beyond, there is sufficient promise in technology to assure the availability of resources, especially when technology is assisted by management to minimize wastefulness and maximize efficiency."

The mounting crime rate also has been blamed on population growth and overcrowding. Recently, Paul Ehrlich (of "The Population Bomb") and Jonathan L. Freedman of Columbia University, reported on a study they had made:

"Perhaps the most remarkable finding is that crowding seems to have little effect on juvenile delinquency or mental illness...There is little evidence that high population density per se produces dramatic effects (positive or negative). Those who predict great loss of efficiency or total breakdown of productive activity are almost certainly wrong."

Conrad Tauber, associate Director of the Census Bureau, has described the many types of positive programs which must be implemented to solve our social problems. He notes, as many other experts do, that a lowered rate of population growth may facilitate the tackling of these tasks--- but this would be only one element which needs to be considered.

Perhaps TIME Magazine sums it up best in its essay, "Population Explosion: Is Man Really Doomed?" (Sept. 13, 1971):

"...the essence of the population problem--so far, at least---is not that mankind has propagated too many children but that it has failed to organize a world in which they can grow in peace and prosperity. Rich nations and poor alike have grossly misused the world's resources, both material and intellectual; neglected them, wasted them, and fought each other over how to share them. Thus, the basic question is not how many people can share the earth, but whether they can devise the means of sharing it at all."

HUMAN LIFE IN THE UNBORN CHILD

Facts: By Petologists as contained in a statement of Dr. Bart Hefferman, Chief of the Department of Medicine at St. Francis Hospital in Evanston, Illinois.

A. THE UNBORN PERSON IS ALSO A PATIENT

From the moment of conception the child is a complex dynamic rapidly growing organism. By the end of the first month the child completes the period of relatively greatest size increase and the greatest physical change of a lifetime. The month old child is 10,000 times larger than the fertilized egg and will increase its weight by six billion times by birth.

By the end of the 7th week we see a well-proportioned small scale baby. In its 7th week it bears the familiar external features and all the internal organs of the adult, even though it is less than an inch long and weighs only 1/30th of an ounce. The body has become nicely rounded, padded with muscles, and covered by a thin skin. The arms are only as printed exclamation marks, having hands with fingers and thumbs. The slower-growing legs have recognizable knees, ankles and toes.

The new body not only exists it also functions. The brain in configuration is already like the adult brain and sends out impulses that coordinate the function of the other organs. The brain waves have been noted at 43 days. The heart beats sturdily. The stomach produces digestive juices. The liver manufactures blood cells and the kidneys begin to function by extraction of uric acid from the child's blood. The muscles of the arms and body can already be set in motion.

FROM THIS POINT UNTIL ADULTHOOD, WHEN FULL GROWTH IS ACHIEVED, SOMEWHERE AT 25 AND 27 YEARS, THE CHANGES IN THE BODY WILL BE MAINLY IN DIMENSION AND IN GRADUAL REFINEMENT OF THE WORKING PARTS.

The development of the child, while very rapid, is also very specific. The genetic pattern set down in the first day of life instructs the development of a specific anatomy. The ears are formed by 7 weeks and are specific and may resemble a family pattern. The lines in the hands start to be engraved by 8 weeks and remain a distinctive feature of the individual.

The prerequisites for motion are muscles and nerves. In the 6th to 7th weeks nerves and muscles work together for the first time. If the area of the lips, the first to become sensitive to touch, is gently stroked the child responds by bending the upper body to one side, making a quick backward motion with his arms. This is called TOTAL PATTERN RESPONSE because it involves most of the body rather than a local part. By the beginning of the 9th week the baby moves spontaneously without being touched. By 8½ weeks the eyelids and palms become sensitive to touch. If the eyelid is stroked the child squints. On stroking the palm, the fingers close into a small fist.

In the 9th and 10th week the child's activity leaps ahead. Now if the forehead is touched he may turn his head away and pucker up his brow and frown. He now has full use of his arms and can bend the elbow and wrist independently.

In the 3rd month the child becomes very active. By the end of the month he can kick his legs, turn his feet, curl and fan his toes, make a fist, move his thumbs, bend his wrists, turn his head, squint, frown, open his mouth, and press his lips tightly together. He can swallow and drink the amniotic fluid that surrounds him. Thumb-sucking is first noted at this age. The first respiratory motions move fluid in and out of his lungs with inhaling and exhaling respiratory movements. By the end of the 12th week the quality of muscular response is altered. It is no longer marionettelike or mechanical - the movements are now graceful as they are in the newborn. The child is active and the reflexes are becoming more vigorous. All this is before the mother feels any movement.

The phenomenon of "quickening" reflects maternal sensitivity and NOT fetal competence. Dr. Javenport Hooker (Petologist) states that fetal activity occurs at a very age normally in utero and some women may feel it as early as 13 weeks. Others feel very little as late as 20 weeks and some are always anxious because they DO NOT perceive movement.

Dr. Liley states: 'Historically, quickening was supposed to delineate the time when the fetus became an independent human being possessed of a soul. However, we know that while he may have been too small to make his motions felt, the unborn baby is active and independent long before his mother feels him. Quickening is a maternal sensitivity and depends on the size and strength of the unborn child.'

Every child shows a distinct individuality in his behavior by the end of the 3rd month. This is because the actual structure of the muscles varies from baby to baby. The alignment of the muscles of the face, for example, follow an inherited pattern. The facial expressions of the baby in his 3rd month are already similar to the facial expressions of his parents.

Dr. Arnold Gessell states that: 'By the end of the first trimester (12th week) the fetus is a sentient-moving being. We need not pause to speculate as to the nature of his psychic attributes but we may assert that the organization of his psychosomatic self is now well under way.'

In the 3rd month the vocal cords are completed. In the absence of air they cannot produce sound; the child cannot cry aloud until birth, although HE IS CAPABLE OF CRYING LONG BEFORE.

Dr. Liley relates the experience of a doctor who injected an air bubble into an eight-month unborn baby's sac in an attempt to locate the placenta on X-ray. It so happened that the air bubble covered the unborn baby's face. The moment the unborn child had air to inhale his vocal cords became operative and his crying became audible to all present including the physician and technical help. The mother telephoned the doctor later to report that whenever she lay down to sleep the air bubble got over the unborn baby's face and he would cry so loud, keeping her and her husband awake!

From the 12th week to the 16th week the child grows very rapidly. His weight increases six times and he grows eight to ten inches in height. For this incredible growth spurt the child needs oxygen and food. This he receives from his mother through placental attachment - MUCH LIKE HE RECEIVES FOOD FROM HER AFTER HE IS BORN. HIS DEPENDENCE DOES NOT END WITH EXPULSION INTO THE EXTERNAL ENVIRONMENT. We now know that the placenta belongs to the baby, not the mother as was long thought.

In the 5th month the baby gains two inches in height and ten ounces in weight. By the end of the month he will be about one foot tall and weigh one pound. The child's mother comes to recognize the movement and can feel the baby's head, arms, and legs. The baby sleeps and wakes just as it will after birth. When he sleeps he invariably settles into his favorite position called his "lie". Each baby has a characteristic lie. When he awakens he moves about freely in the buoyant fluid, turning from side to side, and frequently head over heels. Sometimes his head will be down and sometimes it will be up. He may sometimes be aroused from sleep by external vibrations. He may wake up from a loud tap on the tub when his mother is taking a bath. A loud concert or the vibrations of a washing machine may also stir him into activity. The child hears and recognizes his mother's voice before birth. Movements of the mother, whether locomotive, cardiac or respiratory, are communicated to the child.

In the 6th month the baby will grow about two more inches to become fourteen inches tall. He will begin to accumulate a little fat under his skin and will increase his weight to a pound and three quarters. Now his closed eyelids will open and close and his eyes look up, down, and sideways. Dr. Liley of New Zealand feels that the child may perceive light

CONTINUATION (HUMAN LIFE IN THE UNBORN CHILD)

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through the abdominal wall. Dr. Still has noted that electroencephalographic waves have been obtained in 43 to 45-day-old fetuses AND SO CONSCIOUS EXPERIENCE IS POSSIBLE AFTER THIS DATE.

In the 6th month the child develops a strong muscular grip with his hands. He also starts to breathe regularly and can maintain respiratory response for 24 hours if born prematurely. Dr. Andre Hellegers of Georgetown University, states that 10% of children born between 20 and 24 weeks gestation will survive.

Dr. Arnold Gessell has said: 'Our own repeated observation of a large group of fetal infants (an individual born and living at any time prior to 40 weeks gestation) left us with no doubt that psychologically they were individuals. Just as no two looked alike, so no two behaved alike. One was impassive when another was alert. Even among the youngest there were discernable differences in vividness, reactivity, and responsiveness. These were genuine individual differences, already prophetic of the diversity which distinguishes the human family.'

B. THE DOCTOR TREATS THE UNBORN PERSON JUST AS HE DOES ANY PATIENT

When one views the present state of medical science, we find that the ARTIFICIAL DISTINCTION BETWEEN BORN AND UNBORN HAS VANISHED. Dr. Liley states: 'In assessing fetal health the doctor now watches changes in the maternal function very carefully for he has learned that it is actually the mother who is a passive carrier while the fetus is very largely in charge of the pregnancy.'

CONCLUSION

Those who would remove the protection of law from the lives of the unborn, must prove beyond any doubt that it is not human life they are attacking. So far they have not done so; and, in fact, the foregoing testimony from physicians, long preoccupied with the study of embryonic life, provides overwhelming evidence THAT HUMAN LIFE EXISTS FROM THE VERY EARLIEST STAGES OF GESTATION.

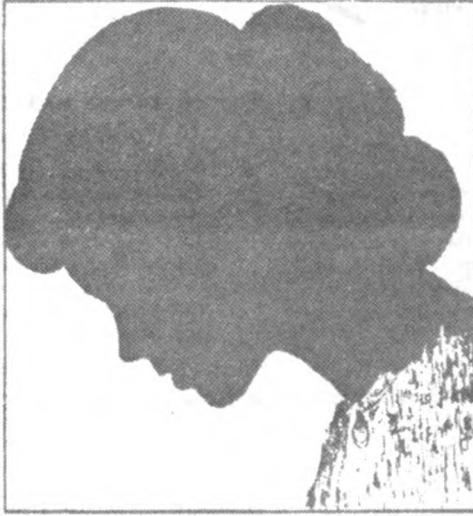
For further information on human life in the unborn child, etc., please write:

PHL (Birthright), P.O. Box 1622, Allentown, Pa., or call 432-2222. Abortion Alternatives - Birthright 432-2222.

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PREGNANT . . .

and Distressed?



BIRTHRIGHT

can help you!

WHAT IS BIRTHRIGHT?

BIRTHRIGHT is an organization with only one purpose: to help women and girls who are pregnant . . . and have problems. This might mean a woman with several children and no one to care for them while she is in the hospital. Or it might mean an unmarried teen-ager afraid to tell her parents. Or it could be a woman separated from her husband and without financial support. Or perhaps it is simply a pregnant girl alone, without friends, and frightened for her future. **ANY** girl or woman with **ANY** problem stemming from pregnancy or complicated by it should seek help from **BIRTHRIGHT**.



WHO IS BIRTHRIGHT?

BIRTHRIGHT is made up mostly of woman volunteers — housewives, nurses, teachers, sisters, social workers. They are your first, sometimes your only contact. They are trained workers who will, if necessary, refer you to agencies or professionals if you need more help than they can give you.

WHAT WILL BIRTHRIGHT DO FOR ME?

Its counsellors will listen, with concern and a sincere desire to understand and help. They will suggest possible solutions and alternatives to your problem. They will seek out social or community services if you need such assistance. If desired, they will keep in touch with you throughout your pregnancy, offering whatever help seems advisable. This might include rounding up used baby furniture or maternity clothes, finding you a temporary place to live, arranging for continued schooling, perhaps helping you to think through decisions about your future and that of your child.

WOULD THEY REFER ME TO AN ABORTIONIST?

No. The people at **BIRTHRIGHT** look upon life as sacred and precious — both your life and the life of your unborn baby. They recognise that no woman **WANTS** to have an abortion, but she might resort to it if there seems to be no other answer. **BIRTHRIGHT** knows that abortion not only ends the child's life, but also damages

the woman psychologically, and perhaps physically. When a woman destroys her child, she also destroys a very real part of her own sexual nature: her deep instinct to protect and nurture her young.

IS THERE A CHARGE FOR BIRTHRIGHT?

BIRTHRIGHT charges no fee at all. If professional services (legal, medical, etc.) are needed, there might be some cost, based on your ability to pay. BIRTHRIGHT services are free because all workers donate their time.

HOW CAN I REACH BIRTHRIGHT?

There are BIRTHRIGHT centers all over the United States. International Headquarters is in Toronto, Canada. Your local (or closest) BIRTHRIGHT office is:

432-2222

**YOU HAVE FRIENDS WHO CARE
AT . . .**

BIRTHRIGHT

One current known statistic is that at present, the number of children foreseeable for each mother is about 2.8 live births, or about $1/3$ more than is needed for replication of a stable population. This figure does not contain in itself the validity it once held. Formerly, prior to the Pill and the I.U.D. (and abortion), the statistic average number of children moved up or down at an exceedingly slow rate; thus it could be used with some reliability in projections.

Today it is apparent that this figure alters quickly but only on the downside. Therefore a second method of computing projections is required. The French demographer Henry saw this need in 1953; it is a highly sophisticated method but one that is close to real life today.

Instead of postulating that each couple will average out to a given number of children in a marriage, Henry suggests that each couple decides after each birth whether or not to have any more children. Today an increasing number of couples are doing just that, and they are doing it with an increasing degree of efficiency. There are fewer and fewer "surprise" pregnancies once a couple has decided "that's it". This element of definitiveness was lacking heretofore; it is a fact of demographic life today.

The Census Bureau has amplified their new Series E to form what it terms Series X; this is a projection which postulates a reproduction of 2.11 children per female and a cessation of immigrational increment. This projection contains a great deal of material for speculation and indeed material for some very

hard thinking. Briefly, if no variables change, the population will level off at 276 million in the year 2037. The median age will be 37.3 years; it is now 27.7 years. Only 20% of persons will be under age 15; the figure is 29% now. About 16% of all persons will be over age 65, up from 10% now.

The hard thinking will be demanded by the elevated rate of deaths. Barring tremendous breakthroughs of a medical nature, it can be anticipated that the death rate will rise from its present figure of 9.5 - 10% up into a range of 14 - 15 deaths per thousand population. Last year our birth rate was in a continuing downtrend and reached 16.8 for whites; for non-whites both birth and death rates are higher.

While the next decade may demonstrate a rise in birth rate per 1000 women, Logie assumes that after this decade the rate will again resume its steady drop and may within this century, perhaps before 1990, drop below the rising death rate. In 1967 at least 14 western countries had birth rates lower than our own; it is thus highly possible, perhaps probable, that we may soon be burying more than we baptize.

In such an eventuality, how would the nation go about fostering an increase in births should such a fostering be indicated by national interest? Similar attempts by Italy and Germany during the thirties met with no success. Premier Date of Japan is now begging his people to stop being aborted. The Greek authorities are now making the same request of their people; Pravda reports that Russia is asking the European satellites to stop aborting themselves into declines. Rumania in desperation reversed its abortion policy in 1966; only this measure seems to be effective in decline reversal.

Other parameters which may have an uninterpretable effect on future population projections include: is homosexuality on the increase and will the increase effect reproduction rates- is childless communal living(pairs or groups) increasing- how will increased college attendance delay male marriages?

Other documentable changes are continuing among the elder cohorts: in 1950 only 53% of women completed their child-bearing between 25 and 29 years of age- in 1969 this figure rose to 66%. The 30-34 year cohort went similarly from 75% in 1950 to 87% in 1969. It is not unlikely that within a few years the child born to a mother over 37 years of age will be a rarity; at present 96% of the 35-39 year cohort has no additional children.

As of March, 1969, there were in the United States 50.5 million families of which 22.2 million have children under the age of 18. The average number of children per childed family is now 2.37. A replication rate of unity is achieved when all ever-married women average 2.22 children. At the present time there is not operative a single parameter that will tend to widen the gap between 2.37 and 2.22.

During the next decade we enter upon what might well be last decade in our history when we have a chance to replicate the immediately preceding generation of mothers. The baby boom after World War II reached its peak in 1957-1959; our median age of first child-bearing indicates that the late years of the coming decade will see greatly increased numbers of 20-29 year old females entering the reproductive scene. The only way in which this cohort can exceed the 4.3 million live births of the 1957-59 peak would be by a simultaneous reversal of how

plummeting cohort-fertility rates, a cessation in the rising attendance at college, a delay in age of final child-bearing, a lowering of median age for marriage and first reproduction, a dramatic increase in multiple births or a profound drop of mortality rates prior to age 15 and 27. Since none of these can be anticipated in the light of current trends (as a matter of fact, not even stabilization of the trends now seems realistically anticipatable), it is difficult to justify a pessimistic fear of a population explosion in the United States.

The cited C.P.R. mentions two facts which need constant repeating. The first is provoked by the fact that the Census Bureau, with the most sophisticated prediction machinery available, could not accurately predict in 1966 what the population would be three short years later. In almost every variable that was capable of serious variation the Census Bureau erred in the direction of overestimation of population and of those factors which increase reproductive rates. To explain this, the Bureau notes: "the prediction of future population is an extremely imprecise and hazardous undertaking".

The second note is more somber. On page 7 of the August C.P.R. is the following: "On the low side some demographers believe that completed fertility could well drop below the replacement values of 2.11 assumed for Series E in view of the current concern with population growth and its effect on environment, along with possible changes in the laws on abortion."

Our population grows in two ways. Intrinsically it grows when generational cohorts out-reproduce numerically the immediately preceding generational cohorts. Extrinsically it grows by net immigration gain, now running at about 400,000 yearly. If immigration is stopped today, there will automatically be

16 million fewer persons in the United States in the year 2000 than will be under our present arrangements. It is thus possible that we will soon choose to face facts in this matter: what do we do, abort our own children or slow down the immigrational inflow rate? In the national abortion debate there has as yet been no serious attention paid to this alternative; almost to a point of silence we have agreed to abort our own on the basis of controlling the American headcount and pollution potential engendered by that headcount.

Whatever the reasons given in legislative debate over the liberalization of abortion, one thing seems to be emerging from the argumental fog: the evidence that abortion is needed to control an American population explosion does not take origin in any official documents of the Census Bureau as now published.

Control of population in the United States is of course a thing apart from control of world population. Of no little geopolitical importance to the United States government is the now fully possible eventuality that our population may within a few decades go into numerical decline while the rest of the west does likewise; what happens when the third world continues to grow numerically, develops a technology, enters world trade and realizes its political potential? One hopes that we are better able to read the future politically than our Census Bureau is able to read our future numerically.

Local Outlook on Growth of Family Planning Services

By
Russell H. Richardson

Last November the National Family Planning Forum ^{1/} surveyed major providers of family planning services to assess the extent of program growth which they anticipate in this and the next fiscal year, and the extent to which this expansion might be financed through Medicaid (Title XIX) and the social services (Title IV-A) programs.

By the end of FY 1972, the national family planning services program had reached nearly half of its original service goal. It can be asked, therefore, whether the rapid growth of recent years -- 24 percent in FY 1969, 32 percent in FY 1970 and 36 percent in FY 1971 -- is likely to continue unabated or whether demand will slacken and program expansion will slow down or taper off in the near future.

The rapid expansion of organized family planning programs has been aided, and paralleled, since 1967 by rapidly rising commitments of federal project grant funds from the Department of Health, Education and Welfare (DHEW) and from the Office of Economic Opportunity (OEO). These funds totalled \$25.8 million in FY 1969, \$44.8 million in FY 1970, \$56.8 million in FY 1971 and \$122.9 million in FY 1972. There were indications, however, when the Legislative Committee of the Forum undertook its survey, that the Administration intended to shift away from its previous support of project grants as the major funding mechanism for family planning programs and towards reliance on Medicaid and Title IV-A as the preferred mode of financing for future expansion. In fact, the revised budget for FY 1973 and the FY 1974 budget, which were sent to Congress by the President at the end of January, would freeze the level of project grant support for family planning

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services at the amount appropriated in FY 1972. However, the budget projected very considerable expansion of overall support for the program, to be secured entirely through Title IV-A and XIX.

Congress, in the 1972 Social Security Amendments, provided strong mandates and incentives for the states to utilize both the social services and Medicaid programs to expand the availability of family planning services.

The Forum survey documents the current level and pattern of utilization of these programs, and, inferentially, sheds some light on what can be realistically expected in the future. The survey encompassed all family planning providers who were recipients of DHEW and/or OEO grants, and all Planned Parenthood affiliates, whether or not they were currently federal grantees. Providers with project grants were asked to give information on the number of patients they served in FY 1972 and the number they expected to serve in FY 1973, and to estimate future program growth in FY 1974 on two bases: likely expansion within their current geographical limits and likely expansion into new areas. They were asked to provide these estimates on the assumption that adequate funds would be available. All programs surveyed were also asked to indicate whether reimbursement was received for services to Medicaid patients and to provide or estimate the number of patients for whom Medicaid reimbursement was received during the year. They were further asked to indicate whether negotiations were in progress to obtain Medicaid reimbursements. Information was also sought as to whether the respondents had Title IV-A programs currently in operation, whether an agreement or contract for the provision of services had been entered into but was not yet operative or whether negotiations were currently in progress.

Four hundred and sixty-one, or approximately half of the agencies surveyed, responded. The respondents included 97 state and local health departments, 163 community action agencies, 133 Planned Parenthood units, 28 hospitals and 40 other

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programs. Three hundred and eighty-nine respondents which had federal project grants reported serving 1.6 million patients in FY 1972, or 60 percent of the estimated total of 2.6 million patients served in all organized programs in that year. Programs of all sizes were well represented. Among DHEW and OEO family planning project grantees, for example, the response rate for programs with grants of \$500,000 or more was 78 percent, between \$300,000-499,000, 54 percent and less than \$300,000, 50 percent.

Substantial Expansion Foreseen

Data on current and projected service levels in federally financed family planning programs are presented in Table 1. It is immediately evident that substantial expansion is foreseen if funding levels are adequate. Within their current operating areas, these programs estimated that they will serve 2.35 million patients in FY 1973, an increase of 48 percent over the previous year and 3.35 million patients in FY 1974, a 42 percent increase. An additional 500,000 patients would be served in FY 1974 in new communities not currently served by the responding programs. Since nationwide increase rates of 24 percent, 32 percent and 36 percent were experienced in fiscal years 1969, 1970 and 1971 by all organized programs (including a large number of programs not receiving federal funds, or at least not directly and specifically for family planning), the growth rates projected by federally funded programs on the assumption of adequate support appear not unrealistic.

In general, the rate of projected expansion is inversely proportional to the size of the program. For example, programs with 500 to 999 patients in FY 1972 projected an average increase of 60 percent for FY 1973, programs with 1000 to 1999 patients projected a 51 percent increase and programs with 2000 or more patients projected increases to 36 to 38 percent. The FY 1973 increase for programs with less than 500 patients in FY 1972 is greatly inflated because of the effect of new

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program starts. In FY 1974 the relationship between size and rate of growth is slightly less apparent. The effect of new starts in small programs is minimized, however, and the growth rate of small programs follows the overall pattern. Although smaller programs tend to experience faster growth rates, the greatest contribution to overall growth is made by the largest programs, most of which are located in urban areas. Programs with 5000 or more patients in FY 1972 contributed well over half the patients making up the overall projected increase between FY 1972 and 1973 for all programs.

Table 1. Expansion of Federally Financed Family Planning Services by Size of Projects, FY 1972-FY 1974

Size of Project in FY 1972 (No. patients)	No. of Projects Reporting	FY 1972 Patients	FY 1973 Patients	Percent Increase, FY 72-73	FY 1974 Patients in Current Project Areas	Percent Increase, FY 1973 to FY 1974	FY 1974 Patients in New Areas	Percent Increase, FY 1973 to 1974 Total Patients
Less than 500	122	23,827	200,749	743	361,802	80	74,912	118
500-999	54	37,005	59,176	60	90,155	52	38,030	117
1000-1999	61	85,919	130,113	51	221,159	70	78,070	130
2000-2999	40	96,043	132,839	38	193,348	46	27,594	66
3000-4999	39	157,684	210,291	38	268,103	27	51,875	52
5000 +	73	1,191,037	1,619,534	36	2,215,750	37	226,091	51
Total	389	1,586,515	2,352,702	48	3,350,317	42	496,572	64

Title IV-A Reimbursement

Title IV-A and Medicaid reimbursement data are presented in Table 2. Of the 461 respondents to this part of the survey (which included some Planned Parenthood affiliates who were not federal grantees), only 34 located in 16 states indicated that they had actually received Title IV-A funds for family planning services. Thirteen of the funded projects were located in California. Another 38 respondents in 14 states indicated that although they had not yet received funds, they had established purchase of service contracts or reimbursement agreements with welfare agencies. One hundred and forty-three family planning providers in 45 states

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indicated that they were currently negotiating with state or local welfare agencies regarding such reimbursement. Four states had no reported Title IV-A activity. Among those family planning providers which have established Title IV-A contracts or agreements or which received reimbursements, about one-third were state and local health departments and one-third were Planned Parenthood units. The remainder were community action agencies, hospitals or other agencies.

These data suggest that although considerable preliminary effort is being made to secure state support of family planning services through this channel, little of the actual mechanism is in place. Furthermore, it seems clear that whether or not the current proposed regulations are in fact adopted by DHEW, eligibility for Title IV-A social services programs will be considerably more restrictive in the future and the relatively small number of existing programs will be cut back in scope. Should the regulations become final with their content essentially unchanged, the very existence of current programs might be in doubt. Similarly, it would appear that the combined effect of the ceiling of social services expenditures and the new regulations will force a restructuring and renegotiation or perhaps the abandonment of pending contracts and agreements previously agreed to but not yet operative. The scope and feasibility of Title IV-A programming in the future can only be a matter of conjecture at this time.

Table 2. Title IV-A and Medicaid Support of Family Planning Programs by Type of Provider, FY 1972

	Number of Providers, by Type					
	Total	Health Department	Community Action Agency	Planned Parenthood	Hospital	Other
Total Number of Survey Respondents	461	97	163	133	28	40
Percent	100	21	35	29	6	9
Title IV-A						
Number with Funds	34	10	7	11	1	5
Percent	100	29	21	32	3	15
Number with Contracts or Agreements, no Funds	38	15	9	10	1	3
Percent	100	39	24	26	3	8
Medicaid						
Number with Funds	122	22	15	64	11	10
Percent	100	18	12	53	9	8

Medicaid Reimbursement

One hundred and twenty-two of the 461 respondents reported that they received some Medicaid reimbursement. Reimbursements were reported in 33 states. Another 110 respondents reported that such arrangements were currently under negotiation. Slightly over half, or 64 of the family planning providers who were currently receiving reimbursements were Planned Parenthood affiliates, located primarily in seven states: New York (17), New Jersey (8), Pennsylvania (7), Michigan (5), Indiana (4), Ohio (4) and Illinois (3). Less than one-fifth of the health departments reporting indicated that they received Medicaid reimbursements.

According to our survey data, Medicaid reimbursement rates for a medical family planning visit ranged from \$3.00 in Nevada to \$42.44 in New York. The median national rate for a medical family planning visit was only \$12.00. However, based on data produced by a cost study conducted by the Westinghouse Population Center, the Department of Health, Education and Welfare (DHEW) has indicated that the average annual cost of providing services to a single patient was \$66.00 in 1971.^{2/} This all-inclusive cost rate includes the basic medical examination, blood tests and other necessary laboratory work as well as all educational and outreach activities necessary to patient enrollment and continuation. DHEW also indicated that safe use of the oral contraceptive (the method chosen by over 70 percent of family planning clinic patients) requires two medical visits per year.^{3/} The median reimbursement rate reported in the survey amounts, therefore, to only 36 percent of the average \$66.00 per patient cost.

State Medicaid agencies, usually a component of state welfare departments, have responsibility for establishing reimbursement rates for the various medical services which the state, through its Title XIX medical assistance plan, has indicated will be available to Medicaid-eligible persons. The survey found that

three states, Maine, New Jersey and Pennsylvania, paid the same rate to all family planning providers surveyed. In other states, however, respondents reported rates which vary among types of providers and which also vary for the same type of provider in different parts of the state. In New York, for example, the Nassau County Medical Center received \$42.44 for a family planning visit. Planned Parenthood affiliates in Buffalo, New York City, Newburgh, and Utica reported rates of \$25.60, \$24.80, \$24.60 and \$23.68, respectively. These variations can perhaps be related to differences among the facilities in costs of providing the service. However, it does not appear likely that the \$5.20 per visit rate reported by the Orleans CAC, Inc. and Planned Parenthood affiliates in Suffolk and Patchogue and the \$10.00 rate reported by the Livingston County Health Department can be similarly attributed to local cost variations.

The Maine Medicaid program has a single maximum reimbursement rate of \$65.00 which providers receive once a year for each patient, regardless of the number of medical visits or the type of contraceptive methods. This rate is very close to the national average per patient cost and was developed on the basis of cost data furnished by the providers. The single payment method has the advantage for the patient of guaranteeing continuous service for a full year. For the provider, it avoids some of the delays and administrative costs related to securing multiple reimbursements during a year.

In March, the Colorado Medicaid program initiated a similar program. Under the new Colorado program, rates, which are predicated on cost estimates, vary among the state's three major family planning agencies. The statewide Planned Parenthood affiliate will receive \$48.17, the state health department, \$55.00 and the Denver Health and Hospital agency, \$56.00.

The Illinois Family Planning Council reported in the survey that it had developed a contract with the state Medicaid agency under which council agencies would receive prepayments ranging from \$40.00 to \$60.00 per patient per year depending on the type of agency. This contract was never implemented, but the Illinois program now reports that all of its member agencies will soon receive payment on a per visit basis and that individual provider rates will be based on costs. These rates will be adjusted every six months to reflect fluctuation in individual program costs.

In contrast to the rates in these statewide programs, the single, standard reimbursement rate in Pennsylvania was only \$4.00 per patient visit. Although raised to \$6.00 in January, neither of these rates can be considered to be cost related.

Under DHEW administrative regulations, state Medicaid agencies must "provide that fee structures will be established which are designed to enlist participation of a sufficient number of providers of service...so that eligible persons can receive the medical care and services included in the plan." In establishing the upper limits for fee structures, the regulations contain criteria that differentiate between in-patient hospital services and services provided by private doctors and those provided by clinics. Since private doctors and clinics are the two main providers of family planning services, the criteria for these two types of providers are most relevant. Payment to a private physician is limited to the lowest of the following: (1) the actual charge for a service, (2) the median of the charge for a given service derived from claims for that service during a year, (3) the reasonable charge recognized under Medicare part B. But in no case can payment exceed the 75th percentile of "weighted customary charges in the same locality" under Medicare, or the "prevailing charge" under Medicare.

The criteria defining the upper limits for clinic services are less specific. State Medicaid agencies are permitted to pay "customary charges which are reasonable." The regulations provide that "the prevailing charges in the locality for comparable services under comparable circumstances shall set the upper limit for payments. In reviewing prevailing charges for reasonableness, the state agency should consider the combined payments received by providers" under Medicare and private insurance companies and use "whichever of these criteria or other criteria are appropriate to the specific provider service." The fact that rates can be related to "other appropriate criteria" enables state agencies to base their family planning rates on the cost experiences of the family planning clinic programs.

The survey data indicate, however, that only a relatively small number of Medicaid payments appear to be related to program costs. There is no documented evidence in the survey itself to indicate the reasons for the sizeable discrepancies between costs and payments. But occasional, individual comments from respondents signal some of the factors involved. Some of the agencies are inexperienced in dealing with the administrative and fiscal complexities of the Medicaid programs and, perhaps, are unaware of the remedies available to them to secure more equitable payments. In other cases, the state Medicaid agency bases its payments exclusively on the costs of the medical examination. It does not consider the ancillary educational and supportive services needed to enroll and maintain the patient under a doctor's supervision. Finally, some Medicaid agencies appear not to recognize the specialized nature of the care provided in organized family planning programs or the costs of laboratory tests required for the safe prescription of modern contraceptive methods.

Since January 1, 1973, the states have been required by law to offer family planning services to all Medicaid recipients. The Medicaid regulations

to implement the 1972 changes in the law, which are yet to be issued by DHEW, could do much to eliminate or ameliorate the obstacles to the development of family planning services which have been noted by providing appropriate guidance to the states.

Among federally financed family planning projects, the proportion of Medicaid-eligible patients served for whom reimbursement was received was less than half. Based on respondents which had federal project grants in FY 1972, only 116,000 Medicaid patients, or about seven percent of all patients served by these programs resulted in Medicaid reimbursements. Since according to DHEW an estimated 16 percent of all patients served in federally financed family planning projects are welfare recipients and since the survey respondents appear otherwise quite representative of federally funded programs generally, one can perhaps assume that roughly the same proportion of patients served by these programs are recipients of public assistance. Some states also provide Medicaid benefits to low-income persons not on welfare and, therefore, the national percentage of patients who have a valid Medicaid card should be in excess of 16 percent of the caseload. Nevertheless, it is apparent that less than half of the services provided to Medicaid eligibles by federally supported family planning programs actually get reimbursed through Medicaid. The survey does not provide information which would shed light on this phenomenon.

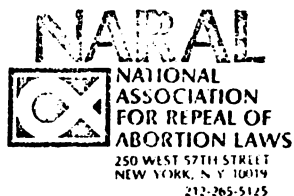
In summary, our survey of a large number of federally financed and other organized family planning programs in the United States indicates that services may be expected to grow significantly, perhaps by as much as 40 or 50 percent, for the next several years if adequate funding remains available. At the same time, however, the ability of the states to finance such programs through Medicaid or Title IV-A would appear to be very limited. While a substantial number of respondents indicated that they were in some stage of negotiation for Title IV-A

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reimbursement, only a small number had established agreements with their respective welfare departments or had actually received funds. Support of family planning through Medicaid appears to be limited as to the number and type of family planning providers which can qualify to receive reimbursement according to state laws, regulations and custom. Furthermore, Medicaid reimbursement rates are quite low and the number of patients for whom reimbursement is received is very small.

The survey indicates that the use of Medicaid and Title IV-A to support family planning services was still sporadic and marginal at the end of FY 1972. The impact of proposed administrative regulations on Title IV-A services is likely to result in curtailment of existing efforts and, at the very least, will severely limit future programming. The wide use of Medicaid to reimburse organized family planning programs may be conditioned by the states' willingness or ability to recognize a variety of agencies as approved Medicaid vendors and to compensate those agencies at a rate commensurate with their actual costs. At any rate, it does not seem possible that the kind of rapid expansion which the local agencies anticipate can be financed in whole or in major part through these two programs in the current year or next year. The expansion which is projected in the federal budget for FY 1973 and FY 1974 for the Title IV-A and Medicaid programs does not seem realizable in view of our survey data.

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- 1/ The National Family Planning Forum is an organization of some 300 family planning providers throughout the country. Its purpose is to improve services through fact finding and the exchange of information among providers, federal and state governments, universities and other concerned organizations. The Forum was founded at Chapel Hill, North Carolina, in March, 1972.
 - 2/ Data and Analyses for 1973, Revision of DHEW Five-Year Plan for Family Planning Services, p. 85.
 - 3/ Interim statement of standards circulated by the National Center for Family Planning Services, March 31, 1972.



Resolution Adopted by the Executive Committee on November 27, 1972

- WHEREAS, the National Association for Repeal of Abortion Laws supports the program authorized by the Family Planning Services and Population Research Act of 1970, and
- WHEREAS, we continue to support the belief that people must be guaranteed freedom of choice in determining family size and spacing of children, so that all children are provided for adequately and the well-being of all parents is maintained, and
- WHEREAS, we further believe it is the duty of the government to provide adequate family planning services to all those who, for economic or other reasons, could not otherwise obtain them and thus be unable to exercise freedom of choice, in accordance with individual conscience, a concept endorsed by the United Nations as a fundamental human freedom to be explored during the U. N. World Population Year 1974, and
- WHEREAS, such family planning services are now provided through programs under the Family Planning Services and Population Research Act which expires June 30, 1973, and which at that time will have served only about half of the 6.6 million women in the United States in need of such services, and
- WHEREAS, the provision of adequate family planning services to all people throughout the world also depends on the development of simple-to-use, safe, and effective methods of birth control so that no one can be forced to bear or beget unwanted children due to religious or societal constraints, ignorance, poverty, poor physical health, or other human conditions which now prevent many people from successfully planning their families, and
- WHEREAS, this country has the wealth and the scientific and technological expertise to develop such desperately needed new contraceptive methods,
- BE IT THEREFORE RESOLVED that NARAL supports the renewal and expansion of programs under the Family Planning Services and Population Research Act, and the removal of any restrictions regarding abortion contained in that act, and
- BE IT FURTHER RESOLVED that NARAL recommends the establishment of the population research programs of this act in a separate Institute for Population Sciences within the National Institutes of Health, as recommended by the Committee on Population and Family Planning under President Johnson and the Commission on Population Growth and the American Future under President Nixon, so that sufficient administrative and scientific personnel and financial resources will be concentrated on efforts to develop new methods of contraception for the benefit of people in the United States and ultimately for the benefit of all mankind.

RESOLUTION ADOPTED BY B'NAI B'RITH WOMEN REGARDING FAMILY PLANNING SERVICES

MARCH 4, 1973

In our continuing belief that freedom of choice must be guaranteed to people in this country with regard to determination of family size and spacing of children, both for the well-being of parents and of children, B'nai B'rith Women expresses its support of the programs authorized by the Family Planning Services and Population Research Act of 1970.

We believe that it is the duty of government to provide adequate family planning services to all those who, for economic or other reasons could not otherwise obtain these services and would, therefore, be unable to exercise their freedom of choice. We further agree that provision of adequate family planning services also depends on the development of safe, effective methods of birth control, so that no one can be forced to bear or beget unwanted children due to ignorance, social pressures, poverty, poor health or other conditions.

Family planning services are now provided through programs under the Family Planning Services and Population Research Act, which expires June 30, 1973; and will then have served only about half the 6.6 million women in the U.S. in need of such services. We support, therefore, the renewal and expansion of programs under the Family Planning Services and Population Research Act. We recommend the establishment of the population research programs of this Act in a separate Institute for Population Sciences within the National Institute of Health, to utilize the scientific and technological expertise of this nation in developing urgently needed methods of contraception for the benefit of all our citizens and ultimately for all mankind.

RESOLUTIONS ADOPTED BY THE

INTERCOLLEGIATE ASSOCIATION OF WOMEN STUDENTS ON MARCH 31, 1973

IAWS strongly urges the United States Congress to continue and expand the Family Planning Services and Population Research Act of 1970 (P.L. 91-572, Title X of the Public Health Service Act), which expires June 30, 1973.

IAWS supports a national health service program that would include coverage of all women's health services, including voluntary family planning services, abortion, infertility, maternity care, and other fertility-related services, without co-insurance or deductibles and without regard to age, marital or economic status.

IAWS urges the United States Congress to adopt legislation to enable public and private nonprofit agencies to establish and operate programs to finance the costs of abortion, pregnancy counseling, adoption services, and other referral services regarding options related to pregnancy. IAWS rejects any effort to coerce women to have or not to have children. We specifically support the current provisions of the following pieces of legislation:

H.R.10240 - Act concerning abortion in military facilities

H.R.14715 - Abortion rights act

IAWS supports the recent Supreme Court ruling on abortion and urges that State Legislation immediately recodify or eliminate state laws to comply with this ruling. We encourage the establishment of certified abortion clinics and sliding fee scales.

RESOLUTION ON POPULATION RESEARCH, PASSED BY THE
INAUGURAL CONFERENCE OF THE OAK RIDGE POPULATION RESEARCH INSTITUTE, MARCH 4-6, 1973

Support for Population Research

WHEREAS the Commission on Population Growth and the American Future, after a careful and thorough two-year investigation of population growth and distribution in the United States, which included the varied problems associated with human reproduction, and the social, behavioral, and economic aspects of human population dynamics, recommended substantial increases in the support of scientific research in these areas, and

WHEREAS the Commission on Population Growth and the American Future also recommended the establishment, within the National Institutes of Health, of a National Institute of Population Sciences to provide an adequate institutional framework for implementing a greatly expanded program of population research, and

WHEREAS major support for existing research in the population sciences is authorized in the Family Planning Services and Population Research Act of 1970 (P.L. 91-572), which expires on 30 June 1973, and which should be renewed and expanded.

NOW BE IT THEREFORE RESOLVED that the Inaugural Conference of the Oak Ridge Population Research Institute supports and endorses the recommendations of the President's Commission on Population Growth and the American Future, that the federal government and private philanthropy increase funding for population sciences research, and that consideration be given to providing a more adequate institutional framework for implementing a greatly expanded biomedical and social science research program on human population problems, possibly by establishing, within the National Institutes of Health, a National Institute of Population Sciences.

STATEMENT OF THE FAMILY PLANNING IN MINORITY COMMUNITIES WORKSHOP HELD IN WASHINGTON, D.C.
MARCH 9, 1973

We deplore the deep cuts by the Administration on the social programs that most acutely affect low-income and minority individuals and families and believe that the policies of this Administration are a forthright attack on low-income and minority individuals and will lead to the abandonment of programs that lead to some hope for the betterment of life for those most in need. As a group of individuals gathered specifically to discuss the delivery of comprehensive family planning services to low-income and minority individuals, we are particularly aware of the basic inequalities which presently exist for the poor of this country, whose environment and health care are already at an unacceptable level.

As minority providers of family planning services in our own communities, we are deeply aware of the effects of unwanted pregnancy and childbearing on the economic and social lives of the members of our communities. Unwanted pregnancy and childbearing contribute to the high infant and maternal death and morbidity rates in the United States, and these mortality and morbidity rates are highest among low-income and minorities. Unwanted pregnancy and childbearing can cause economic crises for individuals and for families and can lead to the deterioration and destruction of families and to dependency of individuals. The human distress and suffering resulting from unwanted pregnancy and childbearing can be averted by the provision of adequate, comprehensive family planning services.

We believe that all persons must be guaranteed freedom of choice with regard to determination of family size and spacing of children so that the well-being of all parents and children may be secured and improved. We believe it is the duty of the government to guarantee such freedom of choice through the provision of comprehensive family planning services to all people who desire them. Such comprehensive family planning services are now provided through programs under the Family Planning Services and Population Research Act which expires June 30, 1973, which at that time will have reached only about half of the 6.6 million women and the many men in the United States who want and need such preventive health services. Low-income and minority individuals have the least access to medical services in general and to voluntary comprehensive family planning services in particular. If this law is allowed to expire, the responsibility for the provision of family planning services would rest with local and state governments. We, and the members of our communities, have no reason to assume that local and state governments will be either willing or able to commit the resources necessary to provide these services nor do we have reason to believe that local and state governments will preserve present national standards for quality of care. We furthermore believe that the development, financing, and monitoring of these programs must come from the federal government in order to insure that local programs are accountable at the national level and that such programs will continue to be both comprehensive and voluntary.

We therefore call upon the President of the United States, members of the Black Caucus, and our elected representatives to take whatever action is necessary to insure renewal and expansion of the Family Planning Services and Population Research Act of 1970 as a means toward improving the health and well-being of all individuals and toward the elimination of poverty and institutional racism from our national life.

NATIONAL WOMEN'S POLITICAL CAUCUS

FIRST ANNUAL CONVENTION

HOUSTON, TEXAS

February 9-11, 1973

EXTRACTED FROM THE RESOLUTION ON LEGISLATION AND THE 93rd CONGRESS

Whereas it is the purpose of the National Women's Political Caucus to protect the interests of women of all backgrounds, economic levels and political affiliations and to take action to eliminate sexism, racism, institutional violence and poverty;

Therefore be it resolved that we support an agenda for the 93rd Congress that would:

Include, in any health security program, coverage of all women's health services (including prenatal, delivery, and postpartum maternity care; voluntary contraceptives, sterilization, abortion, infertility and other fertility-related services), co-insurance or deductibles and without regard to age, marital or economic status. The National Women's Political Caucus rejects any effort to coerce women to have or not have children.

Until the above program becomes reality, continue and expand the Family Planning Services and Population Research Act (Title X of the Public Health Service Act) to provide family planning services and to expand development of new and surveillance of existing contraceptives.

Extend for five years the special project grants for maternal and child health under Title V of the Social Security Act.

Adopt legislation to give public and nonprofit private agencies funds to establish and operate programs to finance the costs of abortion, pregnancy counselling, adoption services and other referral services regarding options related to pregnancy.

1. Continuation of Federal Support for Family Planning Services
and Population Research

In 1970, the American Public Health Association placed itself on record as supporting the establishment and expansion of family planning project grant programs supported by the Federal Government for the purpose of making available subsidized family planning services to all those desiring them. The last report of the Department of Health, Education and Welfare estimated that only approximately one half of the 6.6 million women in need of subsidized family planning services in the United States would be receiving them through special projects for family planning services by the end of calendar year 1973.

Since the job of providing services is only half done while the Family Planning Service and Population Research Act expires as of June 30 1973, the American Public Health Association strongly supports the renewal of the Family Planning Services and Population Research Act of 1970 and the expansion of the programs authorized under this legislation.

Approved by the Council on Population
for forwarding to the
APHA Governing Board
June 23, 1972

2. Population Sciences Institute

The APHA believes that a greatly expanded federal program in population research is needed to insure the health and well being of every American family and to enable us to plan rationally for America's future. We believe that the existing institutional framework of federal programs of research in the population sciences is not sufficient to deal adequately with all problems related to human fertility.

Two years ago this Association went on record in support of S.2108, the Family Planning Services and Research Act which authorized a vastly increased research effort. At the same time, we urged that the Center for Population Research of the National Institute of Child Health and Human Development be strengthened to carry out its enlarged responsibilities. We recommended that it be placed under the direct supervision of the Director for the National Institutes of Health. This recommendation has not been carried out and only a small portion of the funds authorized under the Act have been obligated for population research.

We believe that this vitally important program must be provided an institutional framework in which it can grow and command adequate resources. The APHA therefore endorses the recommendation of the Commission on Population Growth and the American Future that there be established an Institute for Population Sciences in the National Institutes of Health, and urge Congress to act to implement this recommendation as soon as feasible. We concur with the Commission that "creation of a special Institute should provide a stronger base from which this increased effort can be directed. It would facilitate acquisition of qualified personnel, laboratory and clinical space, and other resources necessary for a diversified research program. It would increase the feasibility of the population research program, signal to the world that it ranks high among our research priorities, and should help in commanding the level of funding that we believe is necessary but which has not been forthcoming."

Approved by the Council on Population
for forwarding to the
APHA Governing Board
June 23, 1972

FOR YOUR INFORMATION

Resolution on

Support for Population Research

WHEREAS the President's Commission on Population Growth and the American Future, after a careful and thorough two-year investigation of population growth and distribution in the United States, which included the varied problems associated with human reproduction, and the social, behavioral, and economic aspects of human population dynamics, recommended substantial increases in the support of scientific research in these areas, and

WHEREAS the President's Commission on Population Growth and the American Future also recommended the establishment, within the National Institutes of Health, of a National Institute of Population Sciences to provide an adequate institutional framework for implementing a greatly expanded program of population research, and

WHEREAS major support for existing research in the population sciences is authorized in the Family Planning Services and Population Research Act of 1970 (P.L. 91-572), which expires on June 30, 1973,

NOW BE IT THEREFORE RESOLVED that the American Association for the Advancement of Science supports and endorses the recommendations of the President's Commission on Population Growth and the American Future that the federal government and private philanthropy increase funding for population sciences research and that a more adequate institutional framework be provided for implementing a greatly expanded biomedical and social science research program on human population problems.

Adopted by the Board of Directors,
American Association for the Advancement of Science, March 18, 1973.



By the Committee on Health & Rehabilitative Services
March 21, 1972

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A memorial to the Congress of the United States urging establishment and funding of a population sciences institute.

WHEREAS, the health and well-being of the people of the State of Florida and of the United States are of great concern to this Legislature; and

WHEREAS, the establishment of a population sciences institute and the commitment of increased funding through various research centers for the development of fertility technology is the most effective way to insure the well-being of every American family and to guarantee them freedom of choice with regard to family size; and

WHEREAS, an increased investment in population research is needed in order to determine the appropriate role for governmental policies in dealing with the problems of population distribution and overcrowding and the resultant environmental pollution that now threatens not only our urban and suburban centers and the nation, but also the natural resources and wilderness areas of the State of Florida; and

WHEREAS, in recognition of the fact that the State of Florida and the government of the United

COOKING: Words in italics through 1970 are deletions from existing law; ~~words in bold~~ words are additions.

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States have the capability for leadership in directing research to meet the needs of the citizens of the United States and must carry primary responsibility for the development of fertility technology adequate to the problems of excess unwanted fertility not only of all Americans but also of all the peoples of the world;

NOW THEREFORE:

Be It Resolved by the Legislature of the State of Florida:

Section 1. That the Congress of the United States being empowered with the greatest amount of public trust is hereby requested to enact formal legislation establishing a population sciences institute.

Section 2. That the Congress of the United States appropriate such funds as are necessary to operate the population sciences institute.

BE IT FURTHER RESOLVED that a certified copy of this memorial be forwarded by the Secretary of State to the President of the United States Senate, the Honorable Lavton Chilea, the Honorable Edward Gurney, the Speaker of the House of Representatives, and each member of the Florida delegation to the United States Congress.

- 2 -

Whereas, the Florida Council for Family Planning believes that every individual should be guaranteed the right to plan their own family size, and

Whereas, we believe that all people regardless of income should have the means by which they may exercise this right, and

Whereas, we believe, therefore, it is the duty of the government to secure this right for all people who want family planning services but cannot afford them through subsidized programs for the provision of family planning services, and

Whereas, we estimate that there are still more than 110,000 women in the State of Florida alone in need of subsidized family planning services, and

Whereas, we believe that without programs to provide family planning services to those who could not otherwise afford them, this State will continue to experience increased numbers of births out-of-wedlock and increases in the welfare rolls, unacceptable levels of infant morbidity and mortality among the poor and minority groups, and all the other health, social and economic ills associated with unwanted fertility.

BE IT THEREFORE RESOLVED that the Florida Council for Family Planning supports the renewal and expansion of programs under the Family Planning Services and Population Research Act which expires June 30, 1973, and

BE IT FURTHER RESOLVED that the Council calls on all members of the Florida delegation to the United States Congress to do their utmost to see that this legislation receives immediate and favorable consideration at the beginning of the 93rd Congress.



GUIDELINES

FOR INTERCONCEPTIONAL CARE CLINICS

Family Planning Division
March 1, 1973

FOREWORD

The Guidelines for the Interconceptional Care Program were developed to be of assistance to Family Planning Clinics operating under the administration of the Division of Family Planning of the American College of Obstetricians and Gynecologists. The ICC Project was funded by a grant from the Office of Economic Opportunity.

These Guidelines were reviewed by the Project Directors of the clinics, and approved by the Advisory Committee to the Division of Family Planning of the American College of Obstetricians and Gynecologists.

Family Planning Division
The American College of Obstetricians and Gynecologists
One East Wacker Drive
Chicago, Illinois 60601

Louise B. Tyrer,
M.D., FACOG
Albert W. Isenman,
Administrator

I. Introduction

Family Planning should be available to those needing and requesting it. This is consistent with the objective of providing all women with quality medical care and with the ability to control their reproductive destiny.

Participation in family planning must be entirely voluntary. Informed consent should be obtained prior to examination and treatment. Sterilization is a component of family planning services. Patients should be provided the necessary information to arrive at an informed decision and referral to appropriate sources for this service.

II. Availability of Family Planning Services

Family planning services should be provided wherever other medical services are available. These services should include care of hospital inpatients and outpatients but should not be restricted to these patients exclusively. Patients can be effectively contacted and enrolled in family planning in the hospital and outpatient clinics of a hospital setting. The importance of family planning in overall comprehensive health care of the woman should be stressed. Patients can be oriented to family planning either on a one-to-one basis or in a group session utilizing audio or audio-visual adjuncts, printed materials, and displays of available contraceptive materials. The methods of permanent surgical sterilization, and their implications, may also be presented to the patient where this service is provided. The health aspects involved in the health care delivery system and benefits to the woman of child spacing should be emphasized.

III. Family Planning Clinic Facilities

The family planning clinic should be designed to provide comfort and privacy for the patients, and to facilitate the work of the staff. Deluxe facilities do not necessarily assure the best of patient care, but an uncomfortable, poorly equipped clinic predisposes to hasty processing and inferior service. The location of the clinic, number of examining rooms and physical arrangements should be determined by local conditions. For a small service, one or two examining rooms may suffice, whereas larger programs will require expanded facilities. The minimum requirements, regardless of size, are:

- A. A comfortable waiting room with an area for patient reception, registration, and record processing with nearby storage facilities.
- B. A sufficient number of single, completely enclosed examining rooms, each of which should be provided with an examining table, a chair or stool for the examiner, a good source of light and a writing surface. If the examiner is of the opposite sex, it is recommended that a third party be present during the examination of the patient.
- C. A dressing area where privacy for the patient is assured, either in or adjacent to the examining room. Patients should not be seated in a public area in a dressing gown awaiting examination.
- D. Interviewing offices where histories may be taken, and offices in which physicians, Ob-Gyn family planning associates and assistants, social service workers, health care workers, dietitians and others may interview patients privately.
- E. Adequate toilet facilities near the examining room.
- F. A beam scale and sphygmomanometers.
- G. A conference room for patient and staff education.
- H. Means for procurement of smears for either bacteriologic or cytologic study:
- I. A laboratory in which urine can be examined. If hemoglobin determinations or other blood studies are performed in the clinic, the necessary equipment should be available. A microscope should be available with appropriate light. Slides for examination of a vaginal discharge with saline for trichomonas and 10% potassium hydroxide solution for examination of vaginal discharge for *candida* should be available.

IV. Laboratory Test Collection

If the patient is to have blood work performed, this may be drawn in the clinic by a physician, laboratory technician, nurse, or a technician trained in the technique of venipuncture. The use of disposable needles and syringes is recommended. Containers for obtaining urine specimens should be conveniently located.

and identified with patient's name and number. At the close of each clinic session, the collected laboratory tests should be delivered promptly to the laboratory unless tested at the clinic site. It is most important that GC cultures be plated on Thayer-Martin Media and placed in immediate antibiotic incubation unless holding medium such as Transgrow is utilized. Under these circumstances, some delay in transporting the cultures to the laboratory is acceptable.

V. Equipment and Supplies

- A. Items essential in an examining room include gloves, specula (preferably disposable), all material for taking Pap smears, including glass slides, fixative and spatulas, sterile applicators, and culture media for obtaining GC cultures, plus any other necessary material.
- B. An adequate number of sterile packs for IUD placement with appropriate instruments; two or more sterile packs of instruments to be utilized in IUD removal should be available. A standard set of instruments for IUD insertion or removal should include:
 1. Sponge forceps.
 2. Atraumatic tenaculum. (Example: Sneath's Atraumatic Cervical Tenaculum, Allis wide jaw - Millex Western Company, PO Box 46030, Los Angeles, California 90046).
 3. One double-toothed tenaculum or two single-toothed tenacula (second choice).
 4. Uterine sound.
 5. Cervical dilators.
 6. Sterile IUD.
 7. A straight clamp for IUD removal.
 8. A button hook instrument for removal of IUD without strings.
 9. An intrauterine polyp forcep (optional).
- C. Diaphragm fitting kits, with instructions, should be available. There should be at least one set for every two examining rooms. These should include the coil spring, flat spring and arc type diaphragm.
- D. A sterile setup for paracervical block should be on hand in the clinic.

VI. Medication Available in the Clinic

Medications or treatment should be administered or prescribed under the supervision and direction of a physician. On hand should be:

- A. Simple pain medication (non-narcotic drugs).
- B. Ampules of aromatic spirits of ammonia.
- C. Ampules of adrenalin.
- D. Vials of 1% novocaine, or similar agents (for use in paracervical block).
- E. Vials of antihistamine (e.g. Benadryl).
- F. Vials of an intravenous barbiturate for use in case of convulsive reactions to novocaine.
- G. Laminaria (useful for obtaining cervical dilation to facilitate IUD insertion).

VII. Patient Service

- A. Patient Scheduling. It is preferable to have regularly scheduled clinic appointments so that service may be expedited.
- B. Personnel and Staffing. Personnel and staffing patterns will vary with the size of the operation.
 1. Physician. All clinics should operate under the supervision and responsibility of a physician. Physician backup, either in the clinic or immediately available, is essential. The physician should be well trained in family planning with training in Gynecology, either formally or in training sessions or postgraduate work.
 2. Ob-Gyn Nurse Practitioners. An Ob-Gyn Nurse Practitioner, who is a nurse family planning practitioner, or nurse midwife, may function in a family planning clinic with physician supervision and responsibility. This includes performance of physical examinations, pelvic examination, prescribing contraceptives (including IUD insertions). She may assess problem visits. Responsibilities are to be defined by the clinic director in conjunction with the physician.

3. **Ob-Gyn Assistants.** The medical assistant in Ob-Gyn may perform many of the responsibilities previously delegated to the nurse, as well as some physician's tasks. She is particularly valuable in a large clinic operation, where extensive screening is included.
 4. **Secretaries or Clerks.** A part-time or full-time secretary or clerk is essential.
 5. **Health Care Workers.** Clinics should be encouraged to utilize a trained health care worker for interviews involving initial visits, annual examination visits, and supply visits. The health care worker may conduct the educational program of orientation to the types of family planning available, both on the hospital wards and at the clinic site.
 6. **Social Workers.** The services of a social worker should be available depending on the size and needs of the clinic.
 7. **Outreach Workers.** Clinics should utilize the service of a trained outreach worker to contact patients who have failed to keep clinic appointments. Outreach workers may also participate in patient education in family planning, and assist in clinic operation.
- C. **Initial Visit.** Initial visit patients should have a physical examination which consists of: examination of the head, neck, blood pressure, heart, lungs, abdomen, extremities, pelvic and rectal examination. This may be done by a physician or Ob-Gyn nurse practitioner, who may be a trained family planning nurse practitioner, or nurse-midwife. The pelvic examination should include speculum examination, Pap smear (unless the patient has a normal Pap smear report within the past year), cervical and rectal culture for gonorrhea, microscopic examination of a wet mount of abnormal vaginal discharge, vaginal examination, and recto-vaginal examination. The responsible physician should define the parameters of normalcy. If other than a physician is performing the examination, the examin-

er should be trained to recognize deviations from normal. Where abnormalities are found, physician consultation and appropriate referral and followup are essential.

While the choice of a contraceptive technique is the patient's privilege, it is the physician who must assume the ultimate responsibility as to whether the choice is medically sound, and prescribe accordingly. In the event that the patient's choice is contraindicated, it is the responsibility of the physician and/or examiner to explain this fully to the patient. IUD patients should be seen and examined initially within 3 months after insertion, and then may be followed yearly, unless problems arise. Pill patients should be seen every three to six months for refills and inquiry as to untoward problems. At the time of each refill visit, the weight and blood pressure should be recorded.

It is important that the new family planning patient, as well as patients who are changing methods, have an interview prior to leaving the clinic. This may be carried out by trained professional staff. The purpose of this interview is to make certain that the patient understands the contraceptive technique, accepts the contraceptive prescribed, realizes what side effects to watch for and knows when she is to return for checkup or resupply.

- D. **Annual Examination Visit.** The same procedure should be carried out for the annual examination visit as for the initial visit.
- E. **Pill Refill Visit.** Inquiry should be made as to whether the patient has problems or complaints. If none exists, the weight and blood pressure should be recorded and the patient issued her refill. This may be carried out by the health worker, Ob-Gyn assistant, or nurse. If the patient is given a prescription, it should be current and signed by a physician and may be refillable for one year. When pills are dispensed in the clinic, a current prescription or physician's order, good for one year, should be a part of the patient's record.

- F. **Problem Visit.** The evaluation and treatment at the time of a problem visit will depend upon the complaints and problems of the patient. The interviewer should be well versed in problem evaluation, enabling her to recognize complications and establish priorities. If the examiner is a nurse family planning practitioner or nurse-midwife, physician consultation should be obtained when a complication is suspected or identified.

- G. **Followup and Referral.** Patients who do not keep their scheduled appointments should be followed up in every manner possible, including telephone, letter and outreach visits. Followup should be initiated within one week of the missed appointment, and continued when necessary for a minimum of three months.

Patients who are found to be pregnant, should receive prompt referral for prenatal care or counselling regarding problem pregnancy.

Patients who need special nonmedical service should be appropriately referred, i.e., to the social service department.

Patients who have abnormal laboratory results should be followed up in all instances. When referral is indicated, this should be carried out. Medical referral is indicated where simple treatment of the existing condition cannot be accomplished at the clinic site. Medical referrals are of two types:

1. The referral by the non-physician family planning specialist to the clinic physician.
2. Physician referrals. Referral of the patient, unlike consultation, achieves the transfer of full responsibility to a specialist of greater knowledge, experience, and skill. This is accomplished by written or telephone request of the attending physician and acceptance by the consultant. When the current episode is terminated, the patient should be returned to the referring clinic, with a written report of the specialist's care.

VIII. Laboratory Work

The minimum laboratory work for an initial visit or annual examination visit at the family planning clinic should be:

- A. Hemoglobin or Hematocrit.
- B. Serological test for syphilis.
- C. Cervical and rectal culture for gonorrhea.
- D. Pap smear.
- E. Urinalysis.

Other tests that may be medically indicated and are optional are: pregnancy testing, tuberculosis testing, sickle cell testing, and hemagglutination test for rubella. Abnormal test results require treatment or referral to other sources for care. The patient's record should so indicate.

X. Evaluation

It is important that ongoing evaluation of the clinic, its personnel, facilities and operation be carried out. Each clinic should devise an evaluative outline by which a particular clinic can assess its service. Periodic outside evaluation is recommended by a qualified and experienced evaluation team.

IX. Records

The recorded data, covering the history and physical progress of the patient, plays an important role in contributing to the best possible care of the family planning patient. The medical record is not only a document for reference in the treatment of the patient, but it also reflects the type of care rendered by the clinic and serves as a basis for statistical reports, studies, research and evaluation. A record-keeping system has been evolved by the Division of Family Planning of The American College of Obstetricians and Gynecologists and should be utilized. It includes the history, physical examination, laboratory tests, type of contraception adopted, a problem oriented medical record, related both to contraception and medical-social problems and their management.



THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

SEP 14 1973

Honorable Alan Cranston
Chairman, Special Subcommittee
on Human Resources
Committee on Labor and Public Welfare
United States Senate
Washington, D.C. 20510

Dear Alan:

This is in further response to your letter of June 5 requesting this Department's comments on an analysis prepared by the American Law Division of the Library of Congress concerning the constitutionality of certain proposed amendments to Title X of the Public Health Service Act. You also requested that our comments include a legal opinion by our General Counsel.

We have reviewed the analysis prepared by the Library of Congress and have no specific comment on or criticism of its analysis. With respect to your request for a legal opinion by our General Counsel, I have concluded after further reflection, that such an opinion dealing with constitutional issues should more properly come from the Department of Justice. Accordingly, I have taken the liberty of sending to that Department a copy of your letter for whatever further response they may consider appropriate.

I regret that I cannot appropriately give you a more full response to your inquiry.

Sincerely,

A stylized, handwritten signature in dark ink, appearing to be "J. P. [unclear]".

Secretary

THE AMERICAN PEDIATRIC SOCIETY, INC.

SAUL KRUGMAN
PRESIDENT
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COLLEGE of MEDICINE
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NEW YORK, NEW YORK 10016

MORACE L. HODES
CHAIRMAN of COUNCIL
MOUNT SINAI HOSPITAL
11 E. 108th STREET
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CHARLES B. COOK
SECRETARY-TREASURER
YALE UNIVERSITY
SCHOOL of MEDICINE
333 CEDAR STREET
NEW HAVEN, CONNECTICUT 06510

May 25, 1973

Senator Alan Cranston
452 Old Senate Office Building
Washington, D. C. 20510

Dear Senator Cranston:

At the recent Annual Meeting of the American Pediatric Society in San Francisco on May 18th, two important matters relating to federal legislation were discussed.

It was pointed out that experience with liberalized abortion in some areas has revealed that more than one-third of pregnancies are unwanted and in some economically deprived population groups abortions outnumber deliveries by two to one. The moral issues regarding abortion have been much debated, but even to its advocates abortion is a poor substitute for other contraceptive means, both those presently existing and, hopefully, those more acceptable and effective means which can be developed through research.

Family planning services for the less affluent groups in our country in the past have been inadequate; recently in some areas notable progress has been made, much of it by federally funded projects under the Family Planning Services and Population Research Act (Title X of the Public Health Services Act). Extensive use of legalized abortion indicates the need to maintain and expand these services until they are accessible to all who want them.

Therefore, the following resolution was unanimously adopted by the members of the Society: We urge support of Senator Cranston's proposed legislation which will continue federal support for family planning services and research.

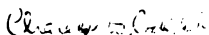
The second important matter pertaining to federal legislation was concerned with the threatened cuts in support of maternal and infant care programs and children and youth projects. In recent years, modest but significant progress has been made in making better health care available to economically deprived women during pregnancy and to their children. Federal assistance under Title V of the Social Security Act has been instrumental in funding both maternity and infant care programs and children and youth projects. Both are now threatened by withdrawal of federal support. In activities where the need is so great and benefits so obvious, discontinuance of these services would be self-destructive. Our federal and local governments have

never been generous in meeting the needs of mothers and children; particularly with this record, the threatened and imminent retrogression is unacceptable.

Therefore the following resolution was unanimously adopted by the members of the Society: We urge continuance of federal support of maternal and infant care programs and children and youth projects as provided by legislation to extend Title V as sponsored by Representative Edward Koch.

We very much appreciate your efforts on behalf of mothers and infants and children and would be delighted to do anything we can to help with the successful passage of these pieces of legislation.

Sincerely yours,



Charles D. Cook, M. D.
Secretary-Treasurer
for the membership of the
American Pediatric Society

CDC/csh



FAMILY LIFE BUREAU

UNITED STATES CATHOLIC CONFERENCE

1312 MASSACHUSETTS AVENUE, N.W. WASHINGTON, D.C. 20005 • 202/659-6673

July 9, 1973

The Honorable
 Alan Cranston
 United States Senate
 2102 NSOB
 Washington, D.C. 20510

Dear Senator Cranston:

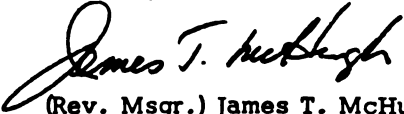
The recent reports of the sterilization of women under the auspices of a federally funded family planning project in Alabama pinpoint the potentiality for coercion that always exists when the poor, the illiterate or other minorities are the target groups to whom family planning services are primarily directed.

As you will recall, in presenting testimony before the Subcommittee on Human Resources during the recent hearings on the Family Planning Research and Services Act of 1973, I emphasized that sterilization should be excluded as a method of family planning because of the finality of the procedure, and because of the unlikelihood that a person will realize the full and long-range effects of such an operation. I believe that the Alabama case provides ample proof of my contention.

The latest reports indicate that HEW has halted funds for sterilization pending the formulation of guidelines. As a matter of fact, guidelines or regulations have always existed since the early days of OEO family planning activity. Quite obviously, they failed to protect women and they also failed to control the family planning personnel. Secretary Weinberger's distinctions between voluntary and involuntary sterilization fail to meet the issue.

I do not believe it is appropriate for the United States government or any of its agencies to utilize sterilization as a method of birth control, and therefore, government funds should not be allocated for projects that include sterilization.

Sincerely,

A handwritten signature in black ink, appearing to read "James T. McHugh". The signature is fluid and cursive, with the first name "James" being more prominent.

(Rev. Msgr.) James T. McHugh
Director

JTM:gw

NGA

naomi gray associates

4444 geary blvd. • san francisco 94118 • (415) 387-5440

July 20, 1973

Senator Alan Cranston
452 - Senate Office Building
Washington, D.C. 20515

Dear Senator Cranston:

I am sure you were as shocked as many Americans when the story broke in the newspaper about the sterilization of two Black children in Alabama. This smacks at the kind of "genocide" which so many Blacks have feared when the federal government moved into the birth control field. As a Black, I have been an advocate of the rights of minorities to birth control information and services and have spent more than twenty years working in this field -- longer than any Black and most whites who are associated with family planning and population control programs today. (I attempted to state my position clearly before the President's Commission on Population Growth and the American Future and to warn against the abuse of sterilization programs and the fears of Blacks in this regard). Those of us who were concerned about the rights of minorities to have access to voluntary family planning services were equally concerned that their rights also be protected.

It would now appear that the federal agencies responsible for administering family planning programs have been negligent in not providing for proper safeguards in monitoring these programs, thus creating an opportunity for the misuse of funds and personnel for encouraging people to accept sterilization as a birth control method.

Equally disturbing are the reports that an experimental birth control drug had been used on these girls prior to the agency taking the final drastic step of sterilization and I daresay that this was done also without the understanding, knowledge, and/or consent of the parents. In these circumstances it is the poor, Black and other minorities who are the most vulnerable. If the federal government has done such a poor job of monitoring its own "voluntary" family planning programs and thereby failing to protect the right of poor, uneducated Black and other women and girls, I shudder to think what will happen when such programs become the responsibility of state and local governments, especially as these programs touch the lives of welfare recipients.

It seems to me that the federal government must get at the bottom of this case and that the Congress of the United States has a responsibility since it has taken leadership for and passed legislation in this field. The majority of Blacks whom I know have been fearful that the federal government's entrance into the birth control business might well result in the current Alabama cause celebre. (It brings back memories of the horrors of the Tuskegee "study" and Hitler's method of getting rid of so-called undesirables.)

*minority-oriented human services consultants • social and health
planners • specialists in family planning*

Senator Alan Cranston

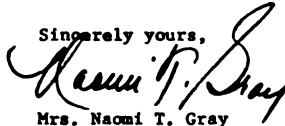
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July 20, 1973

I bring this to your attention knowing of your interest and support of legislation in the population/family planning field and in the hopes that a full investigation of the causes and circumstances will be undertaken and that monitoring of research and other medical practices will be assured to avoid repetition of such cases in the future. The adverse publicity has renewed the charges of "genocide" among many Blacks which some of us had worked so hard to counteract. I would strongly urge and support the barring of funds for sterilization operations in federal programs directed to the poor unless stringent safeguards can be built in to protect the civil rights of those most vulnerable to these actions.

Many minorities are concerned now that Ms. Marjorie A. Costa, the first woman and Black to head a national federal health program is no longer visible in a position of authority and policy-making in the federal government's family planning programs. She had, in a very short time as Director of the National Center for Family Planning Services, gained the support, trust and confidence of minorities and the poor. I would urge her retention, under the HEW reorganization, in a responsible (and not token) position in the national family planning operations so that those of us concerned with the rights of minority and poor families and individuals to receive these services on a voluntary, informed consent basis are not violated again.

Sincerely yours,



Mrs. Naomi T. Gray

NTG/cvj

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